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ABSTRACT

The purpose of the testimony presented before the Subcommittee on Alcoholism and Drug Abuse in April, 1978 was to amend the drug abuse office and treatment act of 1972, thereby extending assistance programs for drug abuse prevention, education, treatment, rehabilitation and other purposes. Speakers represented such organizations as National Institute on Drug Abuse, Alcohol, Drug Abuse and Mental Health Administration, and Rural Alcohol and Drug Agencies. (Author/BMW)

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DRUG ABUSE OFFICE, PREVENTION, AND TREATMENT AMENDMENTS OF 1978

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HEARING

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

OF THE

COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

S. 2916

TO AMEND THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972 TO EXTEND THE PROGRAMS OF ASSISTANCE UNDER THAT ACT FOR DRUG ABUSE PREVENTION, EDUCATION, TREATMENT, AND REHABILITATION, AND FOR OTHER PURPOSES

APRIL 19, 1978

Printed for the use of the Committee on Human Resources

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DRUG ABUSE OFFICE, PREVENTION, AND TREATMENT AMENDMENTS OF 1978

WEDNESDAY, APRIL 19, 1978

U.S. Senate,
Subcommittee on Alcoholism and Drug Abuse
of the Committee on Human Resources,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:36 a.m., in room 4232, Dirksen Office Building, Senator William D. Hathaway (chairman of the subcommittee) presiding.

Present: Senators Hathaway and Hatch.

Opening Statement of Senator Hathaway

Senator **Hathaway**. The subcommittee will come to order.

This morning the Subcommittee on Alcoholism and Drug Abuse will review the administration and implementation of drug abuse prevention, treatment, and research programs under the Drug Abuse Office and Treatment Act of 1972. As you know, authorization under that legislation will expire at the end of the current fiscal year. Therefore, we will also receive testimony today on S. 2916, the proposed extension of the Drug Abuse Act.

Drug abuse continues to be a national problem warranting ongoing Federal leadership, attention, and resources. Counting narcotic-related crime, addicts' lost productivity, and treatment and prevention programs, the total cost to the Nation is an estimated $10 to $17 billion annually. Other drugs, such as amphetamines, tranquilizers, and barbiturates, are actively used for nonmedical purposes by at least 5 percent of the adult population, or among at least 7 to 8 million Americans. So-called polydrug abuse, or use of more than one drug at a time, appears to be reaching epidemic proportions. And the deadly drug PCP, or "Angel Dust," is increasingly becoming a most-favored chemical of abuse, especially among our Nation's youth. The subcommittee has scheduled hearings on June 7 to investigate the PCP problem.

While we must continue our Federal commitment to combat drug abuse, the renewal legislation we are considering today will reauthorize the Federal programs for 1 year only. The primary reason for this is to insure continued congressional scrutiny of the planning and coordinative mechanisms of drug abuse policy at the highest level of the executive branch.

Such a mechanism was established by statute in the Office of Drug Abuse Policy—ODAP—within the Executive Office of the President. However, pursuant to the President's reorganization plan, the functions of ODAP were transferred on April 1 to the domestic policy staff. This transfer was of particular concern to me and a number of my colleagues, including Senator Williams, the distinguished chairman of the Human Resources Committee and member of this subcommittee, and Senator Hatch, ranking minority member of the subcommittee. A simple 1-year extension will enable us to pay close attention to this matter, and to consider these issues once again, 1 year from now, in a legislative context. By then, we will also have the benefit of the Federal Strategy on Drug Abuse, due in June of this year, and the recommendations of the President's Committee on Mental Health. A 1-year extension will enable us to insure that the new policy structure within the White House is responsive to our concerns, and that drug abuse remains in the mainstream of Presidential decisionmaking. I look forward to discussing these issues this morning with Dr. Bourne and other witnesses.

We will also be interested to hear about any proposed changes in the structure and functions of the Alcohol, Drug Abuse, and Mental Health Administration relative to the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. My colleagues and I are particularly concerned that the integrity of each Institute be maintained.

We also anticipate some valuable discussion regarding efforts to prevent drug abuse, and techniques to evaluate whether those efforts are in fact effective. Furthermore, we will be interested to hear about the special needs and circumstances of rural areas with respect to drug abuse functions. These, and other related critical issues, will be the subject of our subcommittee hearings today.

[The text of S. 2916 follows:]

95th CONGRESS
2d Session

S. 2916

IN THE SENATE OF THE UNITED STATES

April 13 (legislative day, February [illegible]), 1978

Mr. Hathaway (for himself, Mr. Williams, Mr. Hatch, Mr. Javits, Mr. Cranston, and Mr. Riegle) introduced the following bill; which was read twice and referred to the Committee on Human Resources

---

A BILL

To amend the Drug Abuse Office and Treatment Act of 1972 to extend the programs of assistance under that Act for drug abuse prevention, education, treatment, and rehabilitation, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Drug Abuse Office, Prevention, and Treatment Amendments of 1978".

Sec. 2. (a) Section 1 of the Drug Abuse Office and Treatment Act of 1972 is amended by striking "Office" and substituting "Office, Prevention,".

(b) The first sentence of section 409 (a) of such Act is amended (1) by striking out "and" after 1977,", and (2)

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by inserting after "1978," the following: "and September 30, 1979,".

(c) Section 410(b) of such Act is amended by adding at the end thereof the following: "For the fiscal year ending September 30, 1979, there is authorized to be appropriated (1) $153,000,000 for grants and contracts under paragraphs (3) and (6) of subsection (a) for drug abuse treatment programs, and (2) $24,000,000 for grants and contracts under such subsection for programs and activities, (other than for grants and contracts under paragraphs (3) and (6) of subsection (a)).

(d) Section 503 of such Act is amended (1) by striking "and" after "1977"; and (2) by inserting after "1978" the following: "and $7,000,000 for the fiscal year ending September 30, 1979".

SEC. 3. (a) Section 405(b) of the Drug Abuse Office and Treatment Act of 1972 is amended to read as follows:

"(b) The Secretary shall transmit a report to the President and the Congress with respect to each fiscal year on—

"(1) the health consequences and extent of drug abuse in the United States,

"(2) a description and evaluation of the effectiveness of the drug abuse prevention functions carried through any entity of the Department of Health, Education, and Welfare in the fiscal year for which the report is made,

"(3) a description of the manner in which such functions were carried out, the amount of funds expended, and a description and evaluation of the coordination within the Department of Health, Education, and Welfare in carrying out such functions,

"(4) a description and evaluation of the effectiveness of experimental methods and programs implemented in carrying out such functions, recommendations for implementation of such methods and programs by others in carrying out their drug abuse prevention functions, and a description and evaluation of the effectiveness of the means used to disseminate information respecting such methods and programs, and

"(5) proposals for changes in the drug abuse prevention functions carried out through the Department of Health, Education, and Welfare (including recommendations for legislation).

The report required by this subsection shall be transmitted not later than January 15 of each year.".

(b) Section 405 of such Act is amended by adding at the end thereof a new subsection (c) as follows:

"(c) Within one hundred-twenty days of the date of enactment of the Drug Abuse Office, Prevention, and Treatment Amendments of 1978, the Secretary shall submit to the Congress a report on the extent and nature of drug abuse in rural areas, the special needs and circumstances which must be addressed in providing drug abuse prevention functions to these areas, and specific recommendations to alleviate drug abuse in rural areas. For purposes of this subsection, 'rural areas' means areas that are nonurbanized areas as defined by the Bureau of the Census.".

(c) Section 502 (b) (3) of such Act is amended by striking "control and treatment" and substituting "prevention, control, and treatment".

SEC. 4. Section 303 (2) of the Drug Abuse Office and Treatment Act of 1972 is amended by inserting immediately after "used" the following: "and shall include a mechanism to identify, provide for, and evaluate effective drug abuse prevention programs, especially for primary prevention designed to discourage persons from beginning drug abuse with equal attention to the needs of metropolitan areas and areas which are not urbanized areas as defined by the Bureau of the Census".

SEC. 5. (a) Section 409 (e) (7) of the Drug Abuse Office and Treatment Act of 1972 is amended to read as follows:

"(7) provide assurance that the State agency will coordinate its planning with local drug abuse planning agencies, and with State and local health planning agencies and educational agencies, as appropriate;".

(b) The first sentence of section 409 (e) of such Act is amended by striking "July 15" and substituting "July 31".

SEC. 6. Section 502 of the Marihuana and Health Reporting Act (Public Law 91-296) is amended by striking out "annually" and inserting in lieu thereof "biennially".

Senator **HATHAWAY.** Before we begin, I would like to urge each witness to summarize his or her testimony. Prepared statements and supporting documentation will be printed in the hearing record in their entirety. We have received and reviewed most of your statements already. Because of the full agenda and limited time, we would prefer to spend this morning discussing these issues with you.

In addition, the subcommitee welcomes prepared statements for inclusion in the hearing record from individuals and groups who are not represented among the witnesses appearing today. I can assure those submitting such statements that their views will be considered carefully in developing any policies on these issues. The hearing record will remain open for 15 days for this purpose.

I understand that Senator Hatch is on his way, but he has asked me to begin the hearing anyway.

Our first witness is Dr. Peter Bourne, and he is accompanied by Lee Dogoloff.

STATEMENT OF PETER G. BOURNE, M.D., SPECIAL ADVISER TO THE PRESIDENT FOR HEALTH, ACCOMPANIED BY LEE DOGOLOFF, DOMESTIC POLICY STAFF, THE WHITE HOUSE

Dr. **BOURNE.** I would like to make a brief summary of my statement, just touching some of what I feel are the most important accomplishments that we have achieved during the last year.

During its 1 year of existence, the Office of Drug Abuse Policy has been a remarkably successful organization in coordinating Federal drug policy. Under the Office of Drug Abuse Policy we were able to establish two major goals for Federal drug programs: One, to reduce the health and social consequences of drug abuse to the lowest level; and second, to reduce the overall consumption of illicit substances that are currently outside the law or used to excess.

I believe we have been really extraordinarily successful and that at the present time health and social costs of drug use in this country are probably at the lowest level that they have been in the last 10 years. Just to cite a few supporting examples of that, I think in the area of heroin addiction, which is the cause of the largest number of drug-related deaths, we have as a result particularly of our program in conjunction with the Mexican Government, reduced the purity of heroin on our streets to the lowest level in 7 years. As a result, there has been a 40-percent drop in overdose deaths in the last 12 months. This in terms of lives saved, by our estimate, amounts to 600 lives that have been saved.

There has also been a concomitant drop in the crime rate nationwide of approximately 5 to 10 percent with some variation from city to city. Although we cannot credit the success of the drug program in its entirety to this, I think reduction in availability of heroin, and in the purity of heroin has contributed significantly to that problem.

Early on in the existence of the Office of Drug Abuse Policy we identified the problem of the excessive use of barbiturates as the second major cause of drug-related deaths, and we took a series of steps to reduce the prescribing of barbiturates and the misuse of barbiturates. As a result of that, barbiturate-related deaths have declined in the last year by 26 percent, and there has been a month-by-month decline in the number of hospital visits nationwide resulting from the misuse of barbiturates.

Senator **Hathaway**. What did you say was the cause of that decline?

Dr. **Bourne**. We have taken six or more specific policy steps. I can briefly go through those.

We initiated a comprehensive review of the prescribing practices relating to barbiturates in conjunction with the Institute of Medicine. We have instructed all federally employed physicians to look for alternatives in place of barbiturates. We are looking at various other ways of discouraging the continuing prescribing of barbiturates, and we have met with the heads of corporations that manufacture barbiturates and solicited their support in reducing any promotional activity to sell those drugs.

I think there is a general recognition on the part of the industry now that the future for that commodity commercially is declining, and they have been extraordinarily cooperative with us in agreeing to terminate any promotional advertisement of barbiturates.

I think perhaps this is the one area in which we made the most dramatic progress of all.

We have in addition conducted seven major policy reviews covering what we felt were the key policy areas. Each of these was a study lasting several months involving representatives from all of the involved agencies and has resulted in seven major reports which we feel serve now as a policy basis for our activities in the Federal Government in each of these areas. I believe you have the one on demand reduction. But there are six others covering everything from international narcotic intelligence to regulatory control, border management, and so forth. In addition we have established biweekly meetings chaired by Mr. Dogoloff and myself in which we bring together the Commissioner of Customs, the Administrator of DEA, the Director of the National Institute on Drug Abuse, and the Senior Adviser for Narcotic Matters to the Secretary of State, and a representative from Secretary Califano's Office. We meet every 2 weeks. We review any major policy issues to be sure that they are coordinated and we discuss how to work out the resolution of any areas of difference or conflict. I think that mechanism has been highly successful and productive, and I think that is a view that is shared by all the participants.

In addition, the Strategy Council that was originally legislatively mandated in the Drug Abuse Office Act of 1972, had a meeting chaired by President Carter on November 7, 1977, and we have expanded that. We included additional members of the Cabinet who were not previously members, as well as appointing six public members. We have established a series of subgroups to the Strategy Council to focus on specific areas of concern that we had. For instance, the role of the Coast Guard and our authority in dealing with ships on the high seas that we knew to be carrying large quantities of drugs, but which were outside our territorial waters. On such complicated issues as those we have set up specific subcommittees of the Strategy Council to try to deal with.

As we move to the future, I think the new coordinating mechanism that has been established in the White House will provide fairly uninterrupted continuity with the Office of Drug Abuse Policy work in the past. The staff is essentially the same, except diminished somewhat. We do not anticipate any substantial change. Our agendas for the coming year include intensification of our effort to reduce the health and social costs of heroin and barbiturates in particular. We plan a major initiative to focus on the major financial transactions that are going on internationally with regard to the shipment of large amounts of drugs. The amounts of money being moved around the world at the present time comes out to hundreds of millions of dollars. It has a very destructive effect as far as corruption is concerned in many countries, in terms of undermining the legitimate economy of those countries, and in strengthening criminal elements, international criminal elements. We plan to focus a major part of our energy and resources in looking at that problem over the next year. That, Mr. Chairman, in summary is what we have been doing in the last year and where we stand at the present time.

Senator HATHAWAY. What area do you think your efforts are the most effective in curbing drug abuse?

Dr. BOURNE. I do not think there is any question but that the international agreements resulting in effective eradication of programs probably have had the best payoff. We could not have accomplished with heroin what we accomplished in the last year if it had not been for a close working relationship with the Mexican Government and their help in implementing the eradication program.

I think without question in the future that is going to be the crucial area. We are also looking at a variety of ways to increase our global surveillance of new poppy-growing areas and to monitor the cultivation of illicit substances.

Senator HATHAWAY. I have read that the spray that they are putting on marihuana in Mexico also poisons it so that if some did get into the country, those who smoke it would be poisoned. Is that true?

Dr. BOURNE. There has been a good deal of publicity related to this area, and some misinformation has ended up being disseminated. Originally we wanted the Mexican Government to get involved in eradicating opium poppies. We provided them helicopters, other support, technical assistance, and they, with our advice, chose to use a herbicide called 2,4-D to eradicate opium poppies. They felt internally their own major drug problem was marihuana and that in part had to do with the large amounts of money made internally in Mexico from marihuana cultivation. They decided then that they would, during the off season for opium, use the helicopters and equipment provided to them by the United States to spray the marihuana fields. We of course had no objection to that, because we are very committed to discouraging the use of marihuana, and to reducing its transportation here. They elected to use a herbicide called paraquat, but this paraquat was bought in Europe with Mexican funds, not with U.S. taxpayers' money. They then proceeded to spray marihuana.

Last summer the issue was raised as to whether any of the marihuana reaching this country was contaminated with paraquat. We then undertook a study over several months involving several of the Federal agencies to look at this issue.

Originally we were somewhat dubious as to whether there was any paraquat on marihuana, and if there was, whether it posed any real health hazard. We found as a result of testing a number of seizures, that as much as 20 percent of the confiscated marihuana was contaminated with paraquat. We had originally anticipated that probably the paraquat would, in being smoked, be destroyed so it would not impose any significant health hazard. Our study found that a certain amount of paraquat does come through and does potentially enter the lungs of marihuana smokers. We felt we had an obligation to make that information available to the American public so that anybody smoking marihuana, even though they are committing an illegal act, should know that in addition to any health hazard imposed by marihuana itself, there was now this additional potential health hazard posed by paraquat.

However, as of this week, there has not been any confirmed instance where anybody smoking marihuana has suffered any demonstrable health hazards as a result of paraquat.

We stated clearly in the HEW release on this issue, that it would require heavy smoking of marihuana over several months period with paraquat contaminating every piece of marihuana that was used. I think, as a result, there may have been unnecessary alarm over the health hazards. We felt it was appropriate for HEW to alert people to that potential hazard, even though in fact it may turn out to be mimimal. That is essentially where we stand at the present time.

We are looking at alternative herbicides. The Mexican Government has agreed to listen to any recommendations we might make, but they have made it clear to us that this is their program, that they make the final decisions, that they are spending their money for it, and we feel very strongly that while we can advise them, we are not in a position to dictate to them what they can or cannot do within their own country.

Senator HATHAWAY. I know you have submitted it to us in a yellow book, and it probably has the breakdown, but could you tell me how extensive the use of illegal drugs is at the present time? Is that figure here in the book?

Dr. BOURNE. Some of the figures are in there. We have some semantic and definitional problems. There are figures I know which Dr. Dupont has provided to you or will provide to you as to the number of heroin users which probably is in the region of about 450,000 heroin users in the country. When one gets to drugs like barbiturates, and others, hypnotics, tranquilizers, one has definitional problems in that people have obtained, in many instances, those drugs from licit sources originally.

Other people may get hold of those drugs and use them illicitly, or people for whom they were prescribed may not be taking those drugs in an appropriate way as the physician who provided them intended. We estimate with cocaine there are probably 1 million people in the country who use cocaine on at least an irregular basis, and as many as 45 million people may have used marihuana, with 8 to 13 million being regular users.

Senator HATHAWAY. Eight to thirteen million?

Dr. BOURNE. Yes. Again, some of these figures are hard to tie down. These are our best estimates using the various mechanisms that we have set up, and I think that we have come quite a long way in refining our process of making those estimates. I think it is important to stress that they are in fact still estimates, and we do not have a defining system for being able to say absolutely this is the exact number.

Dr. DOGOLOFF. We also pulled together that information over a wide spectrum of drug use and misuse in the country and will present that in the Federal strategy that will be coming out in June.

Senator HATHAWAY. What are you doing with the cocaine problem?

Dr. BOURNE. The cocaine problem is a very difficult problem. Based on the goals we set, if we take the criteria of health hazards, cocaine, in fact, despite its widespread use does not present a very substantial health hazard at the present time, in the manner in which it is currently used. There is something in the region of 20 people who died in the last year related to the use of cocaine as compared to roughly 2,000 from heroin. We are talking about something which kills one-hundredth of the people who die from heroin. However, it is a serious problem, and it is a serious problem because it is used on a very widespread basis and because immense amounts of money are being made out of trafficking in cocaine.

It is our belief that one of the reasons that the health hazards are relatively low is because the price is high; because it is high, its use is currently restricted to a relatively small segment of the population that tends to be quite affluent and tends to use the drug primarily in a recreational way. They tend to be people who use it with relatively good judgment.

In addition, cocaine is not addicting so that you do not have the overwhelming craving to get the drug that you have with heroin. So that we have an interesting situation now where the use is very widespread but the consequences from a health or social standpoint are relatively minimal.

Those people who get into serious difficulty with cocaine tend to be people with relatively unlimited resources, frequently people for instance in the entertainment business who are able easily to afford large amounts of cocaine.

At the moment we see some of the biggest problems with cocaine as being related to the large amounts of money being made from it, particularly internationally. Cocaine is grown almost exclusively in Latin America. It has been grown there for more than 5,000 years. It is extremely hard to eradicate, and it has a cultural condonance there that also makes it hard to deal with.

I have made trips to Colombia to meet with the President of Colombia to talk about our problem in dealing with cocaine trafficking. I think we presently have a high level of cooperation with the Colombian Government. Other members of the administration, including Mr. Dogoloff, have been to other Latin American countries. I think we are beginning now to get a level of cooperation in those countries that we have not previously had.

One of the serious problems that we face which we have addressed with the heads of state in those countries is the problem of corruption in their own governments. In the past, they have viewed cocaine as an American problem. Because of what it is doing in terms of undermining their own administrations, and what it is doing to the economies of those countries, there is now recognition that cocaine trafficking is as much their problem as ours, and a willingness to work with us that was not there recently.

It is still a serious problem, but I think we are making some progress.

Senator **Hathaway**. I wonder if you could tell me what your evaluation is of the education effort that has been made so far with respect to drugs. Is it doing any good at all? Can we use the money some place else?

Dr. **Bourne**. I, in the past, have tended to be rather cynical about drug abuse education and prevention programs, not because I do not think they are highly desirable, but I feel we put an awful lot of money in this area in the past that was very well intentioned but for which we did not get very much of a payoff. I think that we still do not have a specific prevention technology where we can say this amount of money put into prevention and education will reduce drug consumption this amount.

I do think that education prevention programs, if they are effective at all, have to be tied to general issues of youth adjustment, not singling out specific drugs, but dealing with problems that lead young people to get into difficulties in a variety of other ways, with the law, with failing grades, with problems in dealing with their peers, in misusing alcohol, in a variety of areas that are not necessarily directly related to drugs. I would like to see us intensify our efforts in dealing with the problems of young people across the board, and not just specifically in drugs.

Mr. **Dogoloff**. In the program in the Office of Education they have trained over 1,000 teams to go out to school districts and to have programs within those schools which do precisely what Dr. Bourne has suggested, which is to mobilize schools and parents to provide better communication between teachers, more sensitivity of teachers to the problems of children and so forth. Some of the evaluation data that is coming back from those programs are very encouraging, but they are encouraging not only for reduction of drug abuse, but also for alcohol use and abuse and delinquency and school grades, and so forth. So there are some positive signs from that program.

Senator **Hathaway**. Would you recommend that we put more money into research and prevention programs, rather than just going ahead as we have in the past and just throwing the money into various so-called models? There are probably 105 different drug and alcohol prevention programs that are being funded. I do not know if we have got any results from any of them or any yardsticks to measure the results.

Mr. **Dogoloff**. I think it is important to identify what it is we know and what it is we need to know regarding drug abuse and alcoholism prevention, and to fund clearly thought-through programs that can demonstrate effectiveness, and to think about those as models with clear evaluation components in them.

In the past year, the National Institute for Drug Abuse has insisted on an evaluation component in every program that they funded, and I think we are going to begin to get some of those results in. I think it is important that the Federal Government spend more money to understand what the causes of drug abuse are, and in that way we can better target our efforts at prevention. We clearly need to know more and need to separate out the Federal function of understanding and research from the service delivery which may be more appropriately carried out at the State and local level.

Senator Hathaway. When ODAP ceased to exist the first of April, what has transpired since? How is that function carried on now?

Dr. Bourne. On a day-to-day basis there has not really been any significant change. The formal administrative aspects of support for activities of ODAP, the budgetary aspects are being transferred to the domestic council, and there is currently a reduction in staff going on. But apart from that, there has been no change in the day-to-day activities of what the staff was doing prior to the phaseout of ODAP.

Senator Hathaway. How many individuals in domestic policy are actually working on drug abuse?

Dr. Bourne. Six.

Senator Hathaway. Six?

Dr. Bourne. Yes, in addition to myself.

Senator Hathaway. Do they report directly to you?

Dr. Bourne. Yes.

Senator Hathaway. Mr. McIntyre last September indicated that you, Peter, would continue to be available to testify before congressional committees, is that your understanding?

Dr. Bourne. Yes, I will be available.

Senator Hathaway. So we do not lose the same function we had before under ODAP. Do you think the role of ODAP is being carried on just as well as it was before, or is it too early to tell?

Dr. Bourne. At the moment it is. I think it is probably too early to tell. In the longrun I think probably any kind of mechanism like there is, is as much dependent on personalities of the players involved as it is the structure that one sets up.

I think at the moment we have the same people involved in the agencies, as we had over the past year, and we have continued in the past few weeks since ODAP no longer existed, to have essentially the same working relationship we had previously and I would anticipate we would have in the future. If we continue to have changes in personnel in the agencies, if they begin to see the relationship purely in terms of whether the same legislative mandate is there or not, for the White House to carry out this role, then things may change. I think we will just have to see how it proceeds over the next 6 months or so, and see if the coordinating mechanism remains as effective as it was during the last year.

Senator Hathaway. How about coordination of HEW? Do you have to clear everything with HEW first?

Dr. Bourne. Well, I have sent an outline of a memo to Secretary Califano indicating what I felt was an appropriate coordinating mechanism. We have had no problems with HEW within the past. I think there may be a lack of familiarity with the history of ODAP, and the specific legislative mandate that ODAP was given to coordinate activities. I have indicated that very clearly in communication to Secretary Califano and have indicated to him what kind of mechanisms I feel are appropriate for us to carry out what the Congress had in mind for us to do.

Senator Hathaway. You do not have to clear things with him before you go ahead and do something, do you?

Dr. Bourne. No.

Senator Hathaway. What is Mr. Meltzer's role?

Dr. **Bourne.** Mr. Meltzer has been designated by Secretary Califano to coordinate with us, which I think is a very positive step. It reflects Secretary Califano's desire to have an active involvement in this area, and to stay personally briefed and knowledgeable about this issue. We have not had a Secretary of HEW previously take this degree of personal interest in this issue.

I see this is an important step in this direction. To carry out the statutorily mandated authority that we have, we obviously have to deal with other people below the Secretary level; as we do with the Department of Justice, Treasury, in all the agencies, we do not deal only with the Secretary's Office and the same is true with HEW.

I think it is a special asset to have that degree of interest and have somebody working directly with the Secretary every day who is also involved in the coordination process.

Mr. **Dogoloff.** It is very helpful, parictularly when we need a position that is a departmental position, which has to be cleared with a number of different aspects or programs within HEW. Mr. Meltzer can then help us to facilitate that process and to get that kind of departmental position. On the other hand, we still reserve the option to deal directly with people when we need technical input, when we need discussion in a less formal way.

Senator **Hathaway.** You mean to say if you want to carry out a certain policy, the Secretary does not have any veto over that, or does he? If you decide the policy is that you are going to drop everything and go after heroin, and the Secretary would say, look, I am interested in the over-the-counter drugs and illegal dispensing by physicians, and so forth, can you say, we are putting that off for a year or two, because we think heroin is much more important, we are going to devote all our time——

Mr. **Dogoloff.** It is my understanding that that is the authority vested in our office. I have proceeded on that assumption. I cannot think of an instance where that has been a problem up to this point.

Senator **Hathaway.** I just understood that there was some problem between the new office and the Secretary's Office.

Dr. **Bourne.** There may in the past have been some lack of awareness of the ODAP legislation, of the fact that the drug area was a very unique area in placing the policymaking authority in the Executive Office of the President. But I think we have overcome that now. I have communicated, I think, very clearly to Secretary Califano that this is a unique situation; it is quite different from what pertains to alcohol, mental health, welfare, or any of the other areas in the Department of HEW. And that policymaking authority was vested by the Congress in the Executive Office of the President. I think that we have made it clear and communicated to him the kind of mechanism that we feel is necessary to carry that out.

Having somebody in his office, I think, will help to facilitate that, but I stressed to him that we had to have immediate access to people with line authority and substantive expertise in the area that were carrying out the programs within the Department. I think we are pretty much on track now at the present time on that issue.

Senator **Hathaway.** So you do not have to wait for something to be cleared by HEW before you go ahead and do it?

Dr. BOURNE. Not in any way that is different from any other department. It is the same kind of situation with all the departments when one is dealing with a department level issue. For instance, if we wanted to make a major change with regard to our foreign policy dealing with Burma because of the drug problem in Burma, obviously we would want to get a signoff from Secretary Vance before doing something that went well beyond the drug area.

So in that sense, with a comparable issue, we would do the same thing in HEW, where we needed Cabinet level endorsement or secretarial level endorsement of our policy.

Senator HATHAWAY. In the State Department instance there might be other considerations involved with respect to Burma, but when we are talking about HEW, there would probably be a difference in the Secretary of HEW's views or what your policy or drug policy ought to be. What I am trying to find out is who is going to have the last say and how long does it take to get the last say?

Dr. BOURNE. Well, as long as I have the legal authority, I plan to have the final say on drug issues. There are obviously gray areas, for instance the relationship between drug abuse and what its role should be in national health insurance, where obviously there are much broader considerations than drugs alone. Those kinds of issues I obviously would not have the final say. I would be in an advocate role more for what I felt was appropriate. But as far as determining what policy should be with regard to drugs, where it is exclusively a drug issue, it is my understanding I have the final say on that.

Senator HATHAWAY. Do you have any formal memoranda outlining the new structure within the Domestic Policy Council and in relationship with the other departments?

Dr. BOURNE. We could provide that for the record.

Senator HATHAWAY. There are memoranda?

Dr. BOURNE. Some. Where there is any lack of clarity, we would be happy to prepare such memoranda.

Senator HATHAWAY. Senator Hatch.

Senator HATCH. I have no questions. Thank you.

Senator HATHAWAY. One last question, Doctor. Could you either state now or furnish for the record material relating to the recommendations contained in the President's drug abuse message of last August and the steps taken by the relevant departments or agencies to implement those recommendations and the timetable for implementing them? I presume you are going to do it for the record.

Dr. BOURNE. Yes, we will.

Senator HATHAWAY. We have some more questions we will ask you for the record. I appreciate that you have answered all the significant ones. Thank you very much for your testimony.

Dr. BOURNE. Thank you.

[The prepared statement of Dr. Bourne and material referred to follows:]

STATEMENT

of

PETER G. BOURNE, M.D.

Special Assistant to the President

before the

Subcommittee on Alcoholism and Drug Abuse

United States Senate

April 19, 1978

Mr. Chairman and members of the Subcommittee, it is a pleasure to be here this morning to discuss the re-authorization of the Drug Abuse Office and Treatment Act of 1972. Since 1972 we have come a long way in understanding the drug abuse problem in the United States, and in organizing and coordinating our government's efforts to deal with it effectively and efficiently.

During the past year I have been Director of the Office of Drug Abuse Policy created by P.L. 94-237 amending the Drug Abuse Office and Treatment Act, and I would like to take a few minutes to outline the progress I think we have made, both in conceptualizing the drug abuse problem and in streamlining and coordinating our Federal programs.

We are dealing with a very different drug abuse problem now than we were in 1972 when we were in the midst of a heroin epidemic, and nearly all of our efforts went to combat heroin addiction. Today, due to the success of our international program, in particular the cooperative opium poppy eradication program of the Mexican government, the availability of heroin in this country has been severely reduced. Heroin availability in the U.S. has sunk in the last twelve months to its lowest level in seven years, with a national average retail purity of five percent and a price of $1.63 per milligram pure. As a result, heroin-related deaths are at the lowest level since this data was available in mid-1973. Deaths have declined over 40 percent since July 1976, and heroin-related injuries show a similar decrease. By our estimate this means the lives of as many as 600 young Americans have been saved in the last twelve months. In addition there has been a drop in the crime rate nationwide of approximately nine percent, which may be attributed in substantial part to a decrease in heroin use.

With this apparent stabilization of the heroin problem we had an opportunity to broaden our focus. The President in his message of August 2, 1977 set two basic policy objectives: first, to reduce the health and social consequences of drug abuse; and second, to reduce all illicit consumption of psychoactive drugs on the assumption that, regardless of the presence or absence of health hazards, the interests of society are not served by the widespread use of illicit drugs.

Therefore, we took a fresh look at all drug-taking behavior in the United States to determine what the negative health and social consequences were and how to reduce them. The ODAP review included pharmaceuticals, like barbiturates and amphetamines, and also generally reviewed the relationship between drug abuse and the excessive use of alcohol and tobacco. The barbiturates ranked nearly as high as the narcotics as a cause of death, and the three categories--barbiturates, narcotics-analgesics and other sedatives including those taken in combination with alcohol--accounted for over 60 percent of all drug-related deaths. Therefore, while continuing to assign top priority to heroin as the major cause of death and drug-related crime, we also gave significant attention to the sedative/hypnotics, directing that a number of specific initiatives be taken government-wide to reduce the morbidity and mortality associated with barbiturate use. Of great concern also is the enormous variety of drugs and combinations of drugs which account for over 40 percent of drug-related deaths and over half of the emergency room incidents. We determined that any attempt to reduce these health and social consequences must focus on destructive drug-taking behavior as a phenomenon, rather than try to distinguish among the vast numbers of substances involved.

In general we have tried to move away from categorizing by drug and from an exclusive emphasis on heroin and to think in terms of the people who take the drugs, either singly or in combination, and how they behave. We have tried to look at the relative health consequences of all drugs regardless of whether their source is from legitimate pharmaceutical manufacturing or from the illicit traffic. And finally, we have broadened our definition of the drug problem to include both drug abuse and drug misuse. We defined drug abuse as the non-therapeutic use of any psychoactive substance including alcohol and tobacco in such a manner as to adversely affect some aspect of the user's life, and drug misuse as the inappropriate use of drugs intended for therapeutic purposes. The drug problem is the sum of the negative medical, social, and economic consequences of drug abuse and misuse as they affect the user, his family and the community at large.

The ODAP not only had a broad focus, it had a wide-ranging mandate to set policy, coordinate all of our Federal programs, and represent our government overseas. I would like to describe some of our accomplishments during the last year and illustrate our role more clearly.

First, we considered international initiatives and cooperation to be essential if we are to reduce the harm caused by drug abuse around the world. Opium and coca, the plant sources of heroin and cocaine, are both grown outside of the U.S. Effective control of the supply of these two drugs in the United States can best be achieved by interdiction at, or as near to the point of cultivation as possible.

We worked with the involved countries to attack illicit supplies of drugs at every point in the distribution chain--from the fields to the processing laboratories, to the transshipment, and finally the sales networks. We have found that cooperative efforts with foreign countries to attack the distribution networks as close to the source of the drugs as possible and to help in the development of substitute sources of income for the local population are most productive. These efforts take advantage of additional border and law enforcement forces for interdiction and concentrate on long-term development to reduce cultivation. In addition, the health and social consequences of drug abuse are felt worldwide with drug abuse occurring more and more among the indigenous populations in previously exclusively producer countries. And, cooperation is needed to share treatment and prevention expertise. Awareness of their own endemic drug problem and appreciation of our willingness to help them solve that problem has helped dramatically to increase the motivation of many countries to deal aggressively with drug trafficking.

ODAP's international role involved bilateral diplomatic negotiations and missions, working with the United Nations and other international organizations, and working toward ratification of the Psychotropics Convention.

I will outline some of the highlights of our international program. Last year I visited Mexico on two occasions to discuss the impressive drug control efforts being undertaken in that country, particularly the opium poppy eradication program, and to ensure that the close working relationships existing between our two governments are continued and where possible, increased. I met twice with President Lopez-Michelsen of Colombia to discuss the drug problems, including corruption, affecting both his country and the United States. I also travelled to the Golden Triangle--visiting Burma, Thailand and Laos--to assess the situation and conduct high-level negotiations.

My Deputy participated in the South American Study Mission conducted by the House Select Committee on Narcotics Abuse and Control in August 1977. The group held meetings with officials of executive departments of individual governments throughout South America, with special emphasis on the coca growing countries of Bolivia and Peru, and the cocaine trafficking networks through Ecuador and Colombia. This joint mission, conducted by members of both the Executive and Legislative Branches of the U.S. Government, demonstrated the solidarity of the U.S. commitment to working with other nations to reduce the cultivation of and trafficking in illicit drugs, and increased the impact of U.S. negotiations.

Other members of the ODAP staff conducted missions to Afghanistan and Pakistan, another area where opium poppies are grown illicitly, and also missions to Singapore, Burma and Thailand.

Finally, the Deputy Director of ODAP travelled to four western European countries including the Federal Republic of Germany to conduct high level discussions on the narcotics abuse problem. The problem is particularly severe in the Federal Republic of Germany where there are reports of dramatic increases in heroin overdose deaths, coupled with high street heroin availability and purity.

We also placed high priority on working with the U.N. family of agencies. Over the past year we worked closely with the United Nations Fund for Drug Abuse Control and the U.N. Commission on Narcotic Drugs to coordinate U.S. policy decisions that will affect member countries. Because of the growing concerns of nations that have been previously untouched by drug abuse among their citizens, the Office of Drug Abuse Policy made every effort, through the United Nations system, to help these countries learn from our past experiences. Last February, at the 27th Session of the U.N. Commission on Narcotic Drugs, I delivered a message from President Carter. That message, the first ever from a head of government, stressed Mr. Carter's concern over the global problem of drug abuse and urged international cooperation to eliminate the world supply of illicit drugs.

The ODAP also worked with the international financial institutions, in particular the World Bank, to encourage them to consider giving priority attention to rural development and income substitution projects in areas which now grow illicit drugs, as well as ensuring that assistance is not used to foster the growth of crops like opium and coca. These projects are long-range general development projects with broader aim than merely crop substitution. Consideration is given to cultural as well as economic issues and work is done in close cooperation with the host country and the international financial institutions.

Finally, in the international arena we worked closely with Members of Congress on implementing the Psychotropic Convention. Legislation implementing the Convention has been introduced in both Houses and we are hopeful of prompt passage.

ODAP has also played a critical coordinating role. Drug abuse functions involve nearly all of the Departments of the U.S. Government and several independent agencies. ODAP had both formal and informal coordinating mechanisms. On occasion it was necessary to work directly with the Cabinet Secretaries on issues requiring a formal response process. However, experience has shown that on a day-to-day basis, Cabinet Members cannot devote substantial amounts of time to one specific issue. Therefore, for the most part, coordination was through the four agencies that are most immediately involved in drug control issues. The principals are the Senior Adviser and Coordinator for International Narcotics Matters to the Secretary of State, The Director of the National Institute on Drug Abuse, the Administrator of the Drug Enforcement Administration, and the Commissioner of the U.S. Customs Service. My Deputy and I met on a bi-weekly basis with these four to discuss matters of particular import. It was at such a meeting that ODAP raised the issue of phencyclidine (PCP), expressing concern about its potential as a model for the marketing of other cheap, easily made, synthetic drugs. ODAP directed that NIDA and DEA formulate a plan for Federal action and coordinated the implementation of the plan which included educational training and research initiatives, as well as the rescheduling of PCP and some of its precursors and analogs. The meetings also offered an opportunity for counterparts to informally discuss their operating problems and seek advice and assistance from the other principals. For instance, the Commissioner of Customs gained the strong support of ODAP when he recently suggested that the ultimate answer to maximizing border control lies in technological advances in detection and surveillance rather than through massive increases in manpower. The meetings provided an opportunity for informal discussion of such matters of mutual interest.

An early decision was made to abolish the many previously existing unwieldy committees and working groups intended to provide coordination. The principals meeting has proved to be a highly effective mechanism in meeting the Congressional desire for interagency coordination and was critical to ODAP's coordinating function.

In its policy-making role ODAP made a wide variety of major decisions during the past year including clarifying Administration policy on marihuana, cocaine, and research into the potential therapeutic uses of abusable drugs. This list is by no means exhaustive. Our entire range of accomplishments will be outlined in ODAP's annual report which will be printed shortly.

Finally, since March of 1977, ODAP conducted seven interagency policy reviews with recommendations for the President. These reviews cover the areas of demand reduction, drug law enforcement, international narcotics control, narcotics intelligence, regulatory and compliance activities, drug abuse assessment in the armed services, and border managment and interdiction. This comprehensive look at the principal Federal drug abuse functions will provide the foundation for the 1978 Federal Strategy on Drug Abuse. Executive Summaries of each review are given in the Annual Report. The President's Reorganization Project in the Office of Management and Budget (OMB) has responsibility for developing specific reorganization plans, and the Office of Drug Abuse Policy has assisted OMB in developing reorganization plans related to these policy reviews.

These reviews with their recommendations provide the basis for a comprehensive program for the coming year which will be implemented by ODAP's successor and the Strategy Council.

Reorganization Plan No. 1 of 1977 took effect on March 26, 1978. At that point the Office of Drug Abuse Policy was abolished and six persons were transferred for budgetary purposes to the Domestic Policy Staff to form the Drug Policy Staff. This staff continues to report to me as Special Assistant to the President for Health Issues and will carry on many of ODAP's responsibilities. The Drug Abuse Policy staff will be supplemented with expertise from other areas of government and from the private sector. In addition to providing Executive Office oversight and coordination functions, the staff will direct special studies to gather necessary data for formulation of Federal policy for the drug abuse programs.

The intent of this transfer is to better integrate drug abuse policy into the mainstream of policy development. However, in response to Congressional concern that active coordination be continued, a visible and active drug policy staff will continue as a unit within the Executive Office of the President. The new organization will better facilitate coordination, both within the White House policy-making process and with the Departments and agencies. In addition, I will continue to be available to the Congress to testify on drug abuse issues.

our relationship with the Congress, which has been both cooperative and productive will not change. We will continue to work as closely with the Congress as we have in the past. The principals meetings, which have been such an important coordinating mechanism, will continue, and our relationship with the Departments and agencies will not change. We will continue to receive technical assistance from all appropriate levels of the Departments as we have in the past, maintaining a free flowing exchange of ideas between the White House and the various areas of expertise.

In addition, we will meet regularly with the involved Departments within the framework of the Strategy Council. The Strategy Council which was created by the Drug Abuse Office and Treatment Act of 1972 has been revitalized and we envision a very active role for it to play.

We held the first meeting of the Strategy Council on Drug Abuse to be chaired by the President on November 7, 1977, in the Cabinet Room, including the Attorney General, the Secretaries of HEW, State, Defense and Treasury, the Administrator of the Veterans Administration, the Director of the Office of Management and Budget, and six members outside the Federal Government. In addition, we have recommended that the Secretary of Labor be added to the Council, in recognition

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of the critical importance that jobs and job training play in the rehabilitation process.

It was decided at the meeting that the structure of the Strategy Council would be issue-related. There would not be standing committees, but the Department of State would take the lead on international issues, the Department of Justice on criminal justice issues, and the Department of HEW on health-related issues, and appropriate ad hoc committees would be formed around each particular problem to stay in existence only until a specific task is completed.

Several working groups and sub-groups have already been formed. The International Affairs Working Group has met and has established four sub-groups to address:

1. Economic development and multinational financing through the international financial institutions of narcotics related assistance projects.
2. Legal issues in the international narcotics program.
3. Consular and narcotics control responsibilities.
4. Worldwide licit supply of and demand for narcotic drugs.

An ad hoc committee of the Strategy Council has been established involving the FBI, U.S. Customs Service, IRS, Treasury

Department's Office of Law Enforcement, Justice Department's Criminal Division, Office of Comptroller of Currency, FDIC and Federal Savings and Loan Insurance Corporation. This group will address the issue of attacking the financial holdings of major drug traffickers through in-depth investigations.

There are also many recommended roles for the Strategy Council in the seven policy reviews and the Council will make sure that these recommendations are carried out. Finally, a Federal Strategy for 1978 as mandated by law will be completed in June.

I believe that the Strategy Council and the Drug Policy Office of the Domestic Policy Staff will provide an effective mechanism for building on and continuing the solid foundation of coordination and policy direction laid by ODAP and I look forward to working with them and with the Members of Congress in the coming year to reduce the harm caused by drug abuse in our country.

I will be happy to answer any questions.

PETER G. BOURNE, M.D.

SPECIAL ASSISTANT TO THE PRESIDENT

Summary of Statement

before the

SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

April 19, 1978

The Office of Drug Abuse Policy has proved to be a highly effective mechanism for coordinating Federal drug policy and this is reflected by the dramatic success achieved in dealing with the drug problem in the last year. It has been made particularly effective because of the President's strong personal interest.

The goals we have established for our national drug policy are:

(1) To reduce the health and social consequences of drug use to the lowest possible level.

(2) To reduce the consumption of all drug substances that are presently used outside the law or to excess.

This Administration sets as its highest priority to reduce drug related deaths, hospital visits and crime.

With heroin, the purity level has been brought down and maintained for nearly a year at the lowest level in seven years. Overdose deaths have dropped 40 percent, meaning that as many as 600 lives have been saved. Crime rate is down around the country between 5 and 10 percent.

- Barbiturates:
  - -- ODAP was concerned that barbiturates were the second cause of drug-related deaths, in 1976, closely following heroin/morphine.
  - -- ODAP directed:
    1. Comprehensive review of relative toxicity and effectiveness of sedative/hypnotics, and government-wide effort to reduce the use of short-acting barbiturates. As a result:

-- DHEW directed all health care facilities to review prescribing practices, and is exploring regulatory and labelling actions.

-- DOD has decreased the use of barbiturates by 80 percent (1972-76) and will further review prescribing, as will the VA.

-- DEA is auditing all 120 barbiturate manufacturers in the U.S.

-- ODAP, NIDA and the Institute of Medicine of the National Academy of Sciences have instituted a major study of the appropriate use of barbiturates, and how to affect the the prescribing practices of physicians.

-- As a result the number of barbiturate-related deaths have declined by 26 percent (from the 1st quarter of 1977 to the 3rd quarter).

- ODAP conducted seven interagency policy reviews covering:

(1) demand reduction
(2) drug law enforcement
(3) international narcotics control
(4) narcotics intelligence
(5) regulatory and compliance activities
(6) drug abuse assessment in the armed services
(7) border management and interdiction.

This comprehensive look at the principal Federal drug abuse functions provides the foundation for the 1978 Federal Strategy on Drug Abuse and establishes Federal drug policy for this Administration.

- Principals Meeting:

ODAP played critical coordinating role, both formally by working with the Cabinet Secretaries, and on a day-to-day basis through the highly effective mechanism of bi-weekly meetings with the heads of the four agencies most directly involved with drug issues:

(1) The Senior Adviser and Coordinator for International Narcotics Matters to the Secretary of State.

(2) The Administrator of the Drug Enforcement Administration.

(3) The Director of the National Institute on Drug Abuse.

(4) The Commissioner of the U.S. Customs Service.

Topical issues, such as how to deal with PCP, and discussions of various agency roles and problems were brought up and dealt with at these meetings. The Principals' Meetings replaced previous unwieldly committees and working groups and will continue to be held.

- Strategy Council:

-- First meeting to be chaired by the President was held on November 7, 1977.

-- Envision an active role, and have recommended that the Secretary of Labor be added.

-- Structure will be ad hoc working groups convened around issues and dissolved when task is completed.

-- International Affairs Working Groups already formed:

1. Sub-group on economic development and multinational financing through IFI's of narcotics-related assistance projects.

2. Sub-group on legal issues.

3. Sub-group on consular and narcotics control responsibilities.

4. Sub-group on worldwide licit supply of and demand for narcotics drugs.

-- Also, Ad Hoc Committee on the issue of attacking the financial holdings of major drug traffickers through investigations.

-- Policy reviews contain other recommended roles for Strategy Council and Council will make sure these recommendations are carried out.

- List of Policy Decisions and Accomplishments of ODAP--from Annual Report.

(1) Policy Decisions:

(a) Marihuana
(b) Cocaine
(c) Research into the Potential Therapeutic Uses of Abusable Drugs
(d) Papaver Bracteatum

(2) Accomplishments:

  (a) International Initiatives:

    -- Work with U.N.

    -- Psychotropic Convention

  (b) President's Message and follow-up

  (c) Study "Estimating Populations of Urban Drug Abusers".

. Aiming for the Future:

-- Further reducing heroin.

-- Mount a better coordinated effort to deal with cocaine.

-- Deal with large international flows of money.

QUESTION:

Could you furnish for the Record material relating to the recommendations contained in the President's Drug Abuse Message of last August, and any steps taken by the relevant Departments or agencies to implement the recommendations contained therein? Timetable for continued implementation?

ANSWER:

The following is a summary of the responses by the relevant Departments and agencies regarding implementation of the President's August 2, 1977 Message to the Congress on Drug Abuse. We will be happy to supply the full responses received to date, as well as any further responses we may receive, if the Committee so desires.

QUESTION:

Could you indicate now, or in writing for the Record, the current status of the Federal Strategy Council--its members, how often it has met, its initiatives, areas of concentration, and timetable for completion of this year's strategy?

ANSWER:

In discussions with Committee staff it was determined that since such information already existed in Dr. Bourne's prepared statement, this question need not be answered here.

QUESTION:

Could you supply for the Record the status of efforts to allow heroin to be utilized for relief of pain among cancer victims.

ANSWER:

Last September Dr. Bourne wrote a letter to Dr. Julius Richmond, Assistant Secretary of HEW for Health, stating that the Federal Government should encourage research into drugs which had potential for therapeutic benefit but which, due to their past history of abuse, were not sufficiently researched. Included in these drugs were heroin and cannabis. In response to this, an Interagency Committee on Pain and Discomfort was established and chaired by the National Institutes of Health. One of its subcommittees focused on the question of determining the potential therapeutic usefulness of heroin for treating individuals suffering intractable pain. The concerned agencies agreed to streamline their approval process for granting investigational new drug applications (IND's) to legitimate researchers in order to determine the safety and efficacy of heroin. Recently the Sloan Kettering Institute has received an IND for this purpose. At the same time, the National Cancer Institute has filed for an IND which will in the future be used by investigators to study the effects of this drug.

The thrust of our initiative is to have heroin treated in the same manner as any drug. This means that heroin will have to be proven safe and effective before it will be widely available for medical use. We are, however, approaching this subject with an open mind and will not allow the drug's past reputation to affect the scientific determination of its usefulness.

QUESTION:

What initiatives if any are being taken to combat abuse of prescription drugs, especially amphetamines (whose legitimate therapeutic use is severely limited) and tranquilizers?

ANSWER:

Over a year ago the Office of Drug Abuse Policy convened an interagency group to study the problem of the abuse of prescription drugs, particularly sedative/hypnotics. The group is composed of representatives of the concerned government agencies, the industry, and the American Medical Association.

At our direction, each of the participating Federal agencies has undertaken initiatives in this area. The National Institute on Drug Abuse (NIDA) has written a widely publicized report on the risks and benefits associated with sedative/hypnotic use. The Department of Health, Education, and Welfare will conduct physician education programs aimed at advising the medical community of the dangers attendant to the abuse of prescription drugs. HEW, DOD, and VA have made information available to physicians working under their jurisdiction which discourages the prescription of certain sedative/hypnotics. DEA is auditing manufacturers of these drugs and is expanding its Diversion Investigation Units to work with state and local authorities in combatting the misprescription of controlled substances. Finally, there are plans for holding a national conference on the appropriate prescribing of drugs, bringing together representatives of all levels of government, the industry, professional associations, regulatory bodies, state medical boards, consumers and the enforcement community. These initiatives have contributed to the 26 percent decline in barbiturate-related deaths in the last year.

Regarding amphetamines, in 1971 the Federal Government moved them from Schedule III to Schedule II. It reduced the quotas for these drugs by 90 percent and did not permit prescription refills. In addition, there were labelling changes noting the drug abuse problems associated with use of those drugs and the fact that they may cause psychological dependence. Also, physicians were warned that amphetamines may be effective for only a short period of time. In view of continuing problems associated with these drugs, and their lack of proven effectiveness, the Food and Drug Administration (FDA) has recently held hearings on whether to remove the anti-obesity indication for them and to require patient package inserts. The FDA has this under consideration.

Tranquilizers were first scheduled in July 1975. Recently FDA proposed a change in the labelling requirement to urge physicians to re-evaluate their patients after four months to determine whether continued prescription of these drugs is necessary. Once tranquilizers were placed under the Controlled Substances Act, the Federal Government could closely monitor their manufacture and distribution. We have been reviewing their impact on health through the Drug Abuse Warning Network (DAWN) system.

ODAP and NIDA have contracted with the National Academy of Sciences, Institute of Medicine, to conduct a research study into the prescribing practices of physicians to determine factors which influence their use of drugs. This information will be helpful in designing a strategy to attempt to limit the misuse and abuse of prescription drugs.

QUESTION:

Are any efforts underway to monitor or control physician's prescribing of certain often abused drugs? Are pharmacies filling prescriptions in relatively large quantities?

ANSWER:

The Controlled Substances Act as adopted by the Congress in 1970 places little responsibility on the Federal Government to control physicians and pharmacies. This duty rests with State and local governments and licensing boards. However, DEA has instituted a system whereby it can identify those pharmacies and dispensing physicians who order particularly large quantities of controlled substances. This data has been made available to the states and a number of them, particularly Wisconsin, are using it to investigate questionable practices. The Drug Enforcement Administration could provide further information on this.

Although the Federal Government has little legal leverage over individual practitioners, we are looking at patterns of drug prescribing. This allows us to determine whether a scheduling change should be made, whether patient package inserts should be required or whether a drug should be removed from the market. The placing of a drug under Federal control, particularly in Schedule II, has a marked effect on its availability for abuse.

QUESTION:

What steps, if any, are being taken to increase the public's awareness of the effects of mixing alcohol and drugs? What are these effects?

ANSWER:

Dr. DuPont will provide the response to this question.

QUESTION:

What is the nature and extent of licit and illicit drug abuse among the elderly? What specific recommendations do you have to address this problem?

ANSWER:

Dr. DuPont will provide the response to this question.

QUESTION:

PCP, Phencyclidine, or "Angel Dust", is readily and cheaply manufactured, produces severe behavioral and physical changes, and appears to have many chemical variations, all equally devastating. It presents an acute problem of coordinating enforcement, treatment and prevention resources. Is the White House taking a special look at this problem?

ANSWER:

The Administration is very concerned about the illicit manufacture and use of PCP. PCP has been a topic of discussion at our regularly scheduled meetings of the Principals involved in the drug area. We are monitoring the work of several Federal agencies which are involved in research, analysis, enforcement, treatment and prevention aspects of combatting illicit PCP use.

On January 25, 1978, PCP was moved from Schedule III to Schedule II. In the Federal Register for March 20, 1978, two precursors of PCP--PCC and 1-phenylcyclohexylamine--were proposed for placement in Schedule II. No comments were received by the April 19, 1978 closing date, so the final order is now being prepared to implement the change. The Drug Enforcement Administration and the Department of Health, Education, and Welfare are working together to develop the documentation necessary for placement of two PCP analogues into Schedule I. The National Institute on Drug Abuse, the Food and Drug Administration and the Drug Enforcement Administration are jointly designing tests and procedures for other PCP analogues to be considered for rescheduling.

In addition to these enforcement efforts, the National Institute on Drug Abuse has developed numerous publications to alert medical and treatment personnel, coroner's offices, other health officials, as well as the lay public to the symptoms and dangers of PCP use. Treatment manuals are currently being developed, as well as prototype training strategies. A national conference was held in February 1978 to assess the state-of-the-art, and PCP has been included in the HEW prevention and education campaign. Studies are currently underway to analyze existing data from the DAWN and CODAP systems, patterns of use, incidence and prevalence, etc.

The Federal Government will continue to give a high priority to the PCP problem, and the White House will continue to oversee the coordination of the Federal effort.

QUESTION:

Could you supply for the Record the formal memoranda or written understandings referred to in your testimony delineating the existing structure for coordinating drug abuse policy within the Executive Office of the President, subsequent to the phasing out of the Office of Drug Abuse Policy?

ANSWER:

Last Fall, OMB and Dr. Bourne provided the Committee information on the proposed structure of the Drug Policy Staff when discussing Reorganization Plan No. 1 of 1977. At that time it was stated that Dr. Bourne would have a staff of four to six people on the Domestic Policy Staff who would report directly to him. The Reorganization Plan has been implemented and the drug staff was created as planned. However, there are no formal memoranda or written agreements which delineate the functions and responsibilities of the new Drug Policy Office, and its relationship with other governmental Departments and agencies. The staff is operating as an extension of the Office of Drug Abuse Policy staff and assumes the same functions and responsibilities as contained in the ODAP legislation.

Senator **Hathaway**. Next we have Dr. Klerman, Administrator, Alcohol, Drug Abuse, and Mental Health Administration, and Dr. DuPont, Director, National Institute on Drug Abuse.

STATEMENT OF DR. GERALD L. KLERMAN, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. ROBERT DUPONT, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. **Klerman**. Senator Hathaway, members of the subcommittee: We are delighted to be here to present the views of the Department of HEW on your bill S. 2916 to amend the Drug Abuse Office and Treatment Act of 1972, to extend the authorizations for programs of assistance under that Act for drug abuse prevention, education, treatment and rehabilitation for 1 year. I am accompanied today by Robert L. DuPont, M.D., Director of the National Institute of Drug Abuse.

In the interest of time I will, with your permission, submit full testimony and just summarize a number of key points.

The most important to begin with, with regard to duration of the authorization, the bill which is under consideration requests 1 year of extension for the authorization for the National Institute of Drug Abuse. With regard to most health authorizations expiring this year, the administration is requesting a 3-year extension. With respect to drug abuse law, we would recommend such an extension, and the administration will be submitting legislation to that effect. However, we do recognize that there may be several good reasons behind the current proposal for a 1-year extension of the drug abuse programs at this time.

With regard to budgetary authorizations, the administration's budget request for the fiscal year 1979 request is $40 million for section 409 and $161 million for section 410, rather than the specific levels contained in S. 2916.

Within this issue recommend and believe that a separate authorization for drug abuse prevention and demonstration activities is unnecessary since these activities the administration believes can be carried out within the general authorization of section 410. In fiscal year 1978, for example, NIDA will expend $15 million on demonstration and prevention activities under section 410.

With regard to reporting requirements, section 3 of the bill mandates the Secretary of HEW to report annually on the health consequences and exten of drug abuse and on the Department's drug abuse program activities, and also changing current requirements for an annual marihuana and health report to 2 years.

We would strongly recommend that you go further with this proposal by consolidating the marihuana report into a biennial report on the health consequences of drug abuse. This recommendation is, in part, a reflection of our joint effort with the General Accounting Office to reduce the number of reports required by statute.

We share the subcommittee's concern that the problem of drug abuse in rural areas be given appropriate attention, as reflected by the subcommittee's wish to receive a special one-time report on drug abuse in rural areas and the amendment of section 303 of the act to require inclusion in the Federal drug abuse strategy of a mechanism to assure development of effective drug abuse prevention programs in both urban and rural areas. Over the last few years, the services research program of the National Institute on Drug Abuse—NIDA—has pursued a rural drug abuse initiative which has included two studies on the differences between rural and urban drug abusers, as well as the special concerns and problems of drug abuse program administrators in rural areas. These studies were published and disseminated to the field with models of program delivery structures particularly appropriate for rural areas recommended. Also, NIDA has amended its national household survey of drug abuse patterns to include an assessment of drug abuse in rural communities in comparison to urban centers. In addition, NIDA, in cooperation with the National Institute of Mental Health—NIMH—and the National Institute on Alcohol Abuse and Alcoholism—NIAAA—is looking at the substance abuse problems of migrant workers. And finally, NIDA is encouraging proposals for demonstration grant assistance to test innovative ways for providing drug abuse services in rural communities.

I recognize the concern from the chairman's comments about the issue of coordination of drug abuse policies. I have discussed this with the Secretary, and we feel confident that the mechanism provided in the White House through reorganization and through the domestic policy staff, and revitalization of the Strategy Council on Drug Abuse as described by Dr. Bourne will be satisfactory, and we feel changes undertaken within HEW to provide better coordination within HEW and better liaison between HEW and the White House will improve the situation.

We look forward to working with the White House on these changes.

We thank you for the opportunity to testify on this bill. We will be pleased to answer whatever questions you have about this specific legislation or other aspects of the program.

Senator HATCH. Thank you, Dr. Klerman.

Recently you received approval from Mr. Califano to consolidate in the ADAMHA Administrator's Office the initial review authority over all grant proposals for the three institutions: NIAAA, NIDA, and NIMH. According to what we have heard, internal memos have leaked far and wide and the constituency groups, particularly in the alcoholism field, are very upset. They see this as a harbinger of the move to merge NIDA and NIAAA, or at least to emasculate policymaking functions of institutes.

Is it your intention to merge or consolidate these separate functions?

Dr. KLERMAN. It is our intention to merge or recommend merger. In fact, the administration is requesting a 3-year extension of the authorization for NIDA. There is no plan within the administration and no discussion that I know of within the administration for changing the basic structure of the three separate Institutes. It is our feeling that the creation of these two new Institutes—the Drug Abuse Institute and the Alcohol Institute—has functioned well to give important visibility and an advocacy role to these programs and the development of these categorical programs has been in the best interest of the Nation.

I could, if you wish, comment on the specific proposal with regard to peer review which is, however, in our opinion intended to strengthen the programs in all three areas rather than to reduce them.

Senator HATCH. I appreciate that. What, if anything, can you do or recommend in order to strengthen the integrity of each Institute under your umbrella organization?

Dr. KLERMAN. I have trouble hearing you.

Senator HATCH. What will you do, if anything, to strengthen the integrity of each of these organizations under your jurisdiction or under your umbrella organization?

Dr. KLERMAN. With regard to individual programs we have attempted to promote the need for increased program visibility and increased authorization and budgetary expenditures. I mean in research, in training, and in clinical services.

With regard to the drug abuse area, we are continuing the basic programs developed by the White House through Dr. Bourne's office. We are involved in strengthening the research program for the Addiction Research Center and possible relocation of that, as recommended in the President's message on drug abuse.

We are reviewing prevention programs on drug abuse in general and how they relate to other prevention programs that are being undertaken by the Department to look for appropriate linkages, particularly in the area of youth, where there is a predisposition in that age group to not only use drugs but also alcohol, smoking, and other problems, and where cooperative effort may be called for.

We are pleased that the President's budget with regard to drug abuse increases the research allotment, and I have worked with Dr. DuPont and Dr. Polan, who is the Research Director, as to how in the future additional funds can be secured.

Senator HATCH. Thank you.

Senator HATHAWAY. Dr. Klerman, it seems it is pretty clear that in section 502 of the alcohol statute, the Secretary acting through the Institute shall by regulation review all research grants.

The same mandate is in section 501 of the drug abuse statute setting up NIDA. Similarly it requires the Secretary to act through the Institute.

It seems to me the step you have taken is probably a violation of the law. I think we ought to clearly spell it out. As I understand the purpose of ADAMHA, it is simply to coordinate these various activities, and not act as a preliminary review for grants. To be sure, you are not the final review, but you do give some evaluation to grant application, and in that way I think have more control over the three areas than is warranted by the statute. Unless you have some reason not to do so, I am going to suggest an amendment to the legislation we are considering that would spell it out even more clearly to make sure that the sections 502 and 501 are clearly carried out.

Dr. KLERMAN. If I might, Mr. Chairman, I think there has been some misunderstanding about the nature of the proposal that we have made and the state of deliberations about it. If I might take a few moments to clarify where matters stand, so that any possible misunderstanding will be minimized, there have been a number of reviews of the management of the grants and contract procedures throughout the Public

Health Service, including in particular the three Institutes that comprise ADAMHA. There are large amounts of funds that are determined in their expenditure through these committees of non-Federal employees. There have been concerns about possible conflict of interest.

A number of recommendations have been made by outside groups, as well as by internal Public Health Service groups with strengthening of the management. I did write to the Secretary, in late February, a memorandum in response to some concerns voiced by his Office and by Dr. Richmond, the Surgeon General, and proposed a series of four options as to how some of these concerns could be best dealt with.

One option, the one that has gained the most attention, is the one which would provide for centralization of the first stage in the two-stage process in the Office of the Administrator.

In the memo which has, as Senator Hatch said, been widely leaked and is available through the Freedom of Information Act, we did identify to the Secretary that before proceeding on any final plan, it would be necessary to get a review of the statutes as to what were the statutory authorizations within HEW, as well as review the reactions of constituency groups. That is actually in process now. No final plan has been submitted to the Secretary and a number of different options are being discussed.

Senator HATHAWAY. Do you not think peer review procedures within each Institute are adequate?

Dr. KLERMAN. I think that would be an advance over what we have now, and that is clearly one of the options, and probably the option that best speaks for the statute as you describe it.

Senator HATHAWAY. You do not have any objection to not doing this any more?

Dr. KLERMAN. We are considering a number of options. As I said, I do not have a final plan——

Senator HATHAWAY. It seems like you are constrained by the law from doing anything like this, unless you disagree with my interpretation.

Dr. KLERMAN. I would not want to disagree with you——

Senator HATHAWAY. Go ahead and disagree with me.

Dr. KLERMAN. The statute, as you say, says the Secretary through the Institutes. You are right, you are absolutely correct——

Senator HATHAWAY. I think that was the intent of the law, to have each Institute do its own review, its own applications.

Dr. KLERMAN. Let me repeat myself. We are considering various alternatives, and that particular one is probably the one which best speaks to the intent of the law.

Senator HATHAWAY. I do not know what basis you would want to review this or change it. Is there some other provision of law that would allow ADAMHA to do this?

Dr. KLERMAN. Legal opinion is being sought by General Counsel for the Secretary's opinion. I would prefer an opportunity to review the matter with the Secretary before making a final response to your comment.

Senator HATHAWAY. It is my understanding the statewide service contract approach of NIDA will soon be adopted by NIAAA with respect to its project grants. Is that right?

Dr. KLERMAN. I have not reviewed that in detail with Dr. Noble. It is my understanding that he is going to look at its possible desirability and feasibility in a selected number of States. It was not my understanding that he intends to make that uniform throughout all the States, but I have not discussed that with Dr. Noble recently. I note there is a desire on the part of many of the States to have the administration of funds in the alcoholism field comparable to that which they feel has proven successful through the drug abuse field, but this is an instance where each of the three Institutes develops their own policy and their own program, and it is an instance that I would have to discuss with Dr. Noble before I would be able to answer your question in detail. My understanding is that he is considering it on a trial basis with a selected number of States; that it is not intended to be uniform.

Senator HATHAWAY. I suppose Dr. DuPont can answer this, too. In the statewide service contract concept, it is simply another layer of formula grant.

Dr. DUPONT. I think the intention was to take advantage of the expertise and administrative capacity of the States in managing project grants as well as handling formula grants, so you get sort of a synergism between the formula grant approach and the project grant approach by working through the States.

In general that has worked very well.

I would say in response to what Dr. Klerman said, NIDA did not do this overnight, either. It has been a 5-year process of working it out, and there are still some States where it does not work as well as it does in others. I think Dr. Noble's approach in not doing it overnight with all the States is probably the right way to go about that, but to do it gradually. It has proven to be a very successful technique.

There are two deficiencies in it. We are working on both of those. One has to do with some of the larger cities who feel they have not had enough input in State planning process, and the other is some minority groups feel that the States are not completely sensitive to and representative of minority interests.

We are working very closely with the States to try to accommodate those two legitimate interests. Other than those, I think it has been a sense that it has worked rather well.

Senator HATHAWAY. Well, in the State where you have a service contract, what is the difference between that and the formula grant?

Dr. DUPONT. The formula grant goes to the State with great discretion of what the State does with the money. For example, the State can put the formula grant into training or primarily into prevention or primarily into rural areas or urban areas. There is great discretion, almost unlimited discretion within the drug abuse definition, and the plan that is approved for the State for the formula grant.

The project grant money, on the other hand, funds a specific number of treatment slots within the States. We contract with them for these numbers of slots. They do not have the option of saying we really do not like that for treatment, we want to use that money, that $5 million or that $300,000 for prevention instead of treatment. We would rather have methadone instead of drug free.

There is a contract that is worked out that gives us accountability, and we can be responsive to the Congress.

They say, OK, we want 102,000 treatment slots nationwide; this statewide services contract allows us to maintain that kind of treatment system, whereas if all the money were in formula grants, we would not. It would change from year to year as States would change their priority. We have a balance. We have $40 million going into the formula grants, with very substantial discretion, and then we have perhaps $100 million going into statewide services contracts for project grants.

It is the balance that is the key to the success of this operation.

Senator HATHAWAY. Under the service contract approach, does the State choose the locations of the treatment centers?

Dr. DUPONT. It is collaborative with NIDA. I think in general we work out an accommodation. Basically our intention has been to try to speak for the places that already have the services, but there is some movement, and we do accommodate ourselves to the States' interest, and they to ours in that regard. Also the amounts in the States. Some States we will find will over time take some treatment slots away; they do not have a need for it. Other States will need more. There is some movement like that. Generally it works out on an agreement basis. If there is a disagreement, however, when it comes to funding the statewide services contract, we as the agency that is controlling the funds, we would have the final say.

Senator HATHAWAY. Can a State department decide how much money is going into each treatment facility?

Dr. DUPONT. They would have to have an agreement with us about that. We would be very sensitive to their interests, but they would have to get our agreement.

Senator HATHAWAY. If they are going to get your agreement on all these things, why do you not fund them directly?

Dr. DUPONT. The reason is we have a very small staff and very substantial program, and we really need the management capabilities of the State to run these programs well and to see that they are part of an overall State network. It is very important to realize that the NIDA money in treatment is more than matched by State investments and by working through the States we are able to bring together the State investment in treatment along with NIDA investment in treatment to form a much more coherent treatment system within that State.

We do have an option of funding directly to projects, and that is the ultimate weapon that we have in negotiations with the State. It is not one we have every played or very rarely simply because we do not have the capacity to manage, and because there are so many advantages to using the States as managers.

Senator HATHAWAY. Does this not create problems for you because certain project recipients in the past under the new service contracts are not getting what they got before, and they are going to come to you and say, hey, the State is not giving us the money we used to get, and asking you to fund them directly. There will be a lot of headaches.

Dr. DUPONT. Yes, we generally work it out with the States. I have not experienced very many projects in the past several years where projects have protested our going to the State for funding. The reason for this is that NIDA treatment funds are on a matching basis. Programs have to come up with non-Federal matching with their treatment programs. An individual free-standing program has almost an impossible task of trying to generate private funds for that match. Once they become part of the statewide services contract, most States will be eager to provide the match out of the State funds. This gives programs a kind of stability to their funding that they simply cannot have as free-standing programs. There is one State in the country, Texas, where the State has not put up any money of its own for treatment. I say any money. I think they are very proud of the fact they went from $115,000 to $150,000 last year. That is less than the State of Vermont puts out, for example. The programs in that State are having a very difficult time coming up with match. I am very worried about the treatment system in the State of Texas. It is a unique problem.

Senator **Hathaway**. Do treatment centers have some input on the States' application?

Dr. **DuPont**. Yes, they work very closely with the States.

Senator **Hathaway**. Is that required by you?

Dr. **DuPont**. I am not sure whether that is required. I do not know about that. But they generally do. One of the things that all States have is advisory boards. It is required by us to have a State advisory board, and I am very pleased that in the audience here you have the national representative for the statewide advisory boards; and as I say, the two issues that we feel we have been perhaps somewhat deficient is getting city representation and minority representation on those minority boards.

Senator **Hathaway**. Your ratio is what, 60–40?

Dr. **DuPont**. That is the floor. The project started out at either 80 or 90 percent Federal funding. Over the course of I think 3 to 5 years, it diminished to 60 percent. We are very proud of our treatment system at NIDA and how we have done this. One of the great achievements has been to establish this floor at 60 percent. That happened 2 years ago, prior to that time all this funding was going to zero, which causes tremendous instability in the programs out there, and by establishing this floor with the support of Congress, we have established the drug abuse treatment system. I am very proud and pleased about that.

Since NIDA has not had any new money for the last 2 years, most of our projects are down to around 62 percent—I think the aggregate is 65 percent Federal funding. In the next couple of years, unless we have new grants starting out at 60 or 90 percent beginning phase, all of our grants will be at 60 percent.

Senator **Hathaway**. Are all of your grants on a statewide service basis?

Dr. **DuPont**. No, most.

Senator **Hathaway**. What percentage?

Dr. **DuPont**. I think probably 90 percent. I will submiit for the record the precise number. That is about right.

Senator **Hathaway**. What evaluation techniques do you employ?

Dr. **DuPont**. We have program development specialists at NIDA. Every NIDA contract has a NIDA officer responsible for that project, including our service projects. They make regular visits to the programs and the States that have statewide services contracts. I do not want to put too much in that. They are one person and they have many programs. In addition, we have, where we have statewide services contracts, we have the monitoring capabilities of the State to go in and assess what is going on in the programs. A third thing we have is a management review which we fund annually. The contract is now held by a management and auditing firm. They go in every 2 years and go over books and program activities, go over these programs. We get a report from them. That has proven to be our most effective monitoring technique.

We have reports on every admission and discharge to the programs. We are able to keep track in general of what the patient flow is, characteristics of the patient population, and the number of patients in treatment. Overall it gives us an imperfect, but still, I think, a pretty good management control over what is going on in those programs.

Senator HATHAWAY. Is this done on a project-by-project basis within the State?

Dr. DUPONT. Every project is controlled by each of these four levels I just described.

Senator HATHAWAY. You get an evaluation on each one of them?

Dr. DUPONT. Yes, sir. Every single one of them.

Senator HATHAWAY. If they are ineffective or inefficient, what do you do?

Dr. DUPONT. One of the things we do not do is defund them, at least not right away. We will try to make them more effective, provide them with technical assistance, try to remedy whatever the deficiencies are, essentially, rehabilitate the program. Sometimes the programs sort of lose the will to survive and they go out of existence. On occasion we will not be able to work things out with the program and there will be a disagreement and we will reduce the funding or even eliminate their funding involuntarily. But usually they either come up to standard or we find an agreeable way to reduce or terminate their funding.

Senator HATHAWAY. Have you had to terminate anybody's funding?

Dr. DUPONT. Yes, we have, several programs.

Senator HATHAWAY. Because they are simply inefficient?

Dr. DUPONT. One program, for example, which just did not have the patients that they said they did, and once we went in with our management review we found a check of their records showed they could not support what we have been paying for them and they went out of business.

Senator HATHAWAY. Dr. DuPont, over the past few months there have been several articles in the national press critical of NIDA, pertaining to allegations of improprieties. I am sure you have become aware of them, the Jack Anderson column of January 18, 19, 23, and March 2. I will put these in the record at this point. I think there have been other articles as well. The New Republic had an article with regard to this.

[The articles referred to follow:]

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THE WASHINGTON POST Wednesday, January 18, 1978 B13

Jack Anderson

About Loading Up on the Largess

This is the story of a clique who climbed to the top of the National Institute on Drug Abuse (NIDA) and immediately began sharing the benefits with friends and relations. Government contracts and fees were parceled out to close associates. And husbands began overseeing contractors who employed their wives. It was all very cozy.

NIDA's $260 million annual budget is supposed to be spent to help the nation's drug addicts kick the habit. But generous amounts have been awarded to contractors and consultants who had close ties to agency officials.

The success story of Lee Dogoloff, a stocky, self-confident official, is a case in point. For two years, he belonged to the tight little circle that ran NIDA. During the same period, his wife, Mary Lou, made thousands of dollars as a consultant to companies with NIDA contracts.

Dogoloff has now gone on to greater glory. He has moved over to the White ... se, where he advises President Car... on drug policy. While he was still at NIDA, Mary Lou Dogoloff was paid at least $7,500 by a New York firm called BRX to work on a NIDA contract. A BRX spokesman solemnly insisted that she was hired under her maiden name. But other company officials told us they knew her as Dogoloff's wife.

Mary Lou has also collected at least $7,200 on another NIDA contract. This one was granted to a Maryland firm called Macro Systems, Inc. But Lee Dogoloff swore he had nothing to do with her hiring. "I cannot control what contractors may do," he told our reporters Valerie Strauss and Howie Kurtz. "My wife is a respected professional independently."

In 1975, Dogoloff took his wife with him on an official trip to Thailand as a government-paid note-taker. He paid his wife's plane ticket, but the taxpayers paid for everything else, including her salary.

Recently, Mary Lou Dogoloff was almost hired directly by NIDA as a $140-a-day consultant. Her proposed assignment was to rewrite a report she had previously prepared for a contractor. "If the report was inadequate," grumbled one NIDA insider, "why should she be paid by the taxpayers to work on it a year later?" The complaints prevailed, and the $140-a-day offer was withdrawn.

The romance of Lee and Mary Lou Dogoloff, like their marriage, was rooted in their work. They met at a narcotics treatment center in Washington. The program was run by Robert DuPont, who is now the NIDA director. As he moved up in the drug abuse world, the Dogoloffs ascended with him.

The three of them were also close to Dr. Richard Katon. They did not forget one another as their paths branched out. DuPont and Dogoloff moved over to NIDA, where they gained control of larger budgets. Katon formed a consulting firm, which wound up with several lucrative NIDA contracts. And Mary Lou joined Katon as a high-paid consultant.

Before the wedding bells tolled, Dogoloff supervised a Katon contract while his fiancee was on Katon's payroll. Even after they were married, Dogoloff conceded that he had signed a couple of work orders for his wife.

Both Dogoloff and Katon claimed that Mary Lou resigned from the consulting firm soon afterward to avoid conflicts.

In 1974, Katon lost a $1 million contract when it came up for renewal. Dogoloff had been removed from the review committee because of complaints that he might favor his friend, Katon.

The contract had been awarded, meanwhile, to a firm called RPC. Under the terms, RPC was supposed to administer 100 drug programs. But, curiously, the agency didn't assign any programs to RPC for several months. Dogoloff had already authorized Katon to go ahead with 13 drug programs.

Both Dogoloff and Katon insisted these programs were not taken from the 100 that RPC was supposed to handle. Yet RPC ended up working on only 87 programs, precisely 13 short of the 100 the firm should have been given.

A few months later, according to inside sources, an incensed Dogoloff tried to cancel RPC's contract altogether. NIDA officials had to tell him this would be illegal.

As for Katon, the doctor now has more than $1 million in NIDA contracts. Agency officials have sometimes seen him wandering around the contracts office, where confidential information is closely guarded. One time, he was firmly asked to leave. But Katon declared: "I have never gone to the contracts office to get advance information."

Competent sources have told us that, in the past, Katon and Dogoloff have discussed the details of pending NIDA contracts on the phone. Both men have denied the charge.

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THE WASHINGTON POST Thursday, Jan. 19, 1978 DC 9

Jack Anderson

Drug Unit Funds: All in the Family

The rarefied air of high government office has an intoxicating effect on some officials. They get the idea they are not bound by the rules that govern ordinary men. This has been the attitude of the clique that runs the National Institute on Drug Abuse (NIDA).

In an earlier installment, we reported that the agency's top officials have been overseeing government contracts and fees to insiders who sometimes turn out to be their wives. Now we have discovered another man-and-wife deal among NIDA's research grants.

Although public officials aren't supposed to be associated with any firm that receives money from their agency, NIDA official Laurence Carroll and his wife, Guinevieve, have been principal stockholders in such a firm. The feisty, blunt-spoken Carroll was one of the incorporators of a Miami-based consulting firm called Social Systems, Inc.

At least four states have funneled NIDA funds into this favored company. Florida, for example, gave the company $40,000 in 1975 to run a drug-training program.

Carroll removed his name from the firm sometime in 1975, but his wife's name still appears as a director. Carroll insisted to our reporters Valerie Strauss and Howie Kurtz that "there's no longer any connection with our family." Any listing of his wife's name, he said, "must be a legal error."

Declared the combative Carroll: "I allowed my name to remain on longer than I should have." Then he produced a letter from Social Systems stating that the company has never paid him any fee or dividend. He also contended the firm never received money from his agency and that his wife was never paid out of federal funds.

But Florida officials informed us, on the contrary, that they paid the company $40,000 in NIDA funds. And under a contract with Nebraska, the firm hired Carroll's wife as a consultant. She was paid with federal funds, the company president acknowledged.

Carroll is now preparing to retire from NIDA and is looking for a job in Miami. On a government-paid trip to Miami, he met with a University of Miami professor and discussed a future job.

The same Carroll, meanwhile, oversees $250,000 in government grants and contracts which go to the University of Miami. He claimed he saw the professor "during off hours. I don't see any conflict."

There have been many other irregularities in the awarding of NIDA contracts. Some examples:

- During the Nixon years, a $2 million contract was awarded to Dr. John Mendelson, a Massachusetts researcher. The official who handled the contract, Dr. Nancy Mello, requested $8,000 so two investigators could inspect a drug program in Hong Kong.

After the money was approved, Dr. Mendelson married Dr. Mello, and the couple had a honeymoon in Hong Kong. Mendelson told us that both are qualified investigators, that they completed their research in Hong Kong and that federal money paid for only part of the trip. The rest was financed by private donors, he said.

- NIDA computers are supposed to keep track of thousands of drug addicts and treatment programs. But officials have secretly used the machines to compute the batting averages of players on local baseball teams and to monitor an office football pool. The top brass at NIDA insist this extra-curricular activity has been halted.

- In 1976, a Maryland firm called Macro Systems, Inc., offered Frederick Harrison a consulting job on a NIDA contract; at the time, he was on the review board which was awarding the contract. Harrison said he was unaware of Macro's job offer because it was made through a member of his staff. In any case, he did not accept the offer.

But, interestingly, Harrison gave Macro top marks. "Excellent staff selection . . . outstanding," he wrote. A Macro spokesman told us "it was all very innocent. As soon as we realized we had approached someone who was on the review board, we dropped the arrangement."

- The University of Miami ran a large NIDA drug training center for several years. Although NIDA official Lonnie Mitchell certified that the university did an excellent job, the school lost the contract in 1976 to A. L. Nellum Associates, even though the university's bid was $100,000 lower than Nellum's.

A. L. Nellum conceded that he and the NIDA official are "good friends," but insisted that Mitchell did not help him win the contract.

Insiders say NIDA director Robert DuPont spends more time gallivanting around the world than tending to his office. But those who complain have had their jobs downgraded.

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THE WASHINGTON POST Monday, January 23, 1978 C23

Jack Anderson

Drug Agency Abuses Overlooked

We have uncovered evidence that the National Institute on Drug Abuse (NIDA) is plagued with corruption and cronyism. Yet strangely, the improprieties were overlooked by the House committee which is supposed to oversee the agency.

The House Select Committee on Narcotics Abuse and Control criticized NIDA recently for spending $260 million a year on "fragementary" and "wasteful" programs. The committee also found "layers of unnecessary bureaucracy" and a "serious deficiency" in the monitoring of grants and contracts.

But the committee completely missed the contracts-for-cronies and husband-and-wife deals that we exposed last week in a series of columns. Nor does the committee plan to investigate the abuses now that they have been reported.

The chief counsel, Joseph L. Nellis, told us he doesn't have enough investigators to pursue the allegations properly. It is an interesting coincidence that among the influential wives holding NIDA contracts, we discovered Nellis' wife, Muriel. She was awarded a fat $150,000 contract to study women's drug problems.

The big, gravel-voiced Nellis quickly explained that his wife won her first NIDA contract in 1975, before his committee was formed. "My wife's contract preceded my connection with this committee by almost two years," Nellis told our reporters Valerie Strauss and Howie Kurtz.

But Muriel Nellis is now working on a NIDA contract that was granted in March, 1975. This was at the same time her husband was directing a House investigation of the agency—the same investigation that ignored serious irregularities.

The able Nellis said he sees nothing wrong with his wife's bidding for NIDA contracts while he was investigating the institute. "It's her business. It has nothing to do with me. She's an expert," he insisted. "I'm not very well liked at NIDA. I can't imagine anyone giving her a break because of me."

But according to Mrs. Nellis' account, NIDA Director Robert L. DuPont tried to take advantage of her marital relationship. Shortly before the House narcotics committee held hearings last fall on NIDA's performance, she recalls being approached by the tall, smooth-talking director. DuPont asked her: "Hey, Muriel, what's your husband got in store for me?"

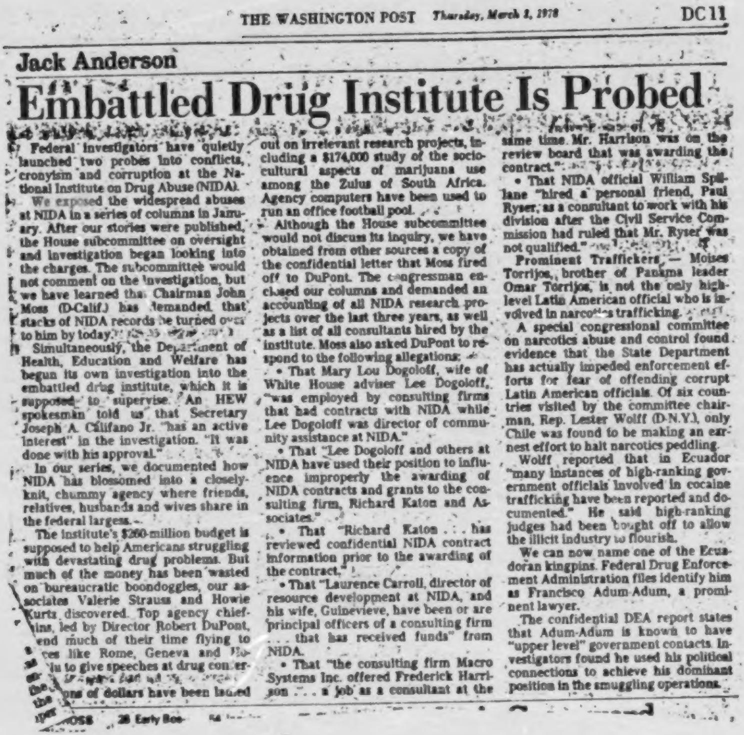
As Mrs. Nellis remembers the incident, "He wanted some information in advance. I told him never again to raise Joe's name or the committee's work in my presence."

DuPont denied ever seeking such information. "I've never discussed the committee with Muriel in any context in all the time she has dealt with NIDA," he said.

Although the committee missed the mark and left the serious charges uninvestigated, DuPont was indignant over the lesser criticism of the wasteful, bureaucratic deficiencies at NIDA. He marched up to Capitol Hill and complained bitterly to Chairman Lester L. Wolff (D-N.Y.). The congressman has a reputation for his vigorous narcotics investigations, but he relied upon his staff to check out NIDA. He flatly rejected DuPont's protest.

We have already reported several improprieties that the committee would have discovered if it had dug a little deeper. Here are some more:

- Some NIDA officials flouted Civil Service regulations to give agency jobs to their friends. For example, NIDA official William Spillane tried to line up a high-paying job for his college chum, Paul Ryser, who also co-authored a book with him. When the Civil Service Commission ruled that Ryser wasn't qualified, Spillane hired him anyway as a consultant. Ryser later went to work for Richard Katon, a private consultant who began getting several contracts from Spillane's division. "I had a certain ignorance of the Civil Service regulations," Spillane explained.
- Some NIDA contract reviewers have been pressured to change the ratings they give to competing bidders. Eyewitnesses have told us that Spillane once urged reviewers to increase the scores of a firm that won a NIDA contract. This would head off a possible complaint from the runner-up, he said. But Spillane insisted to us there was "no way" he would pressure anyone to change the scores.



THE WASHINGTON POST Thursday, March 2, 1978 DC11

Jack Anderson

Embattled Drug Institute Is Probed

Federal investigators have quietly launched two probes into conflicts, cronyism and corruption at the National Institute on Drug Abuse (NIDA).

We exposed the widespread abuses at NIDA in a series of columns in January. After our stories were published, the House subcommittee on oversight and investigation began looking into the charges. The subcommittee would not comment on the investigation, but we have learned that Chairman John Moss (D-Calif.) has demanded that stacks of NIDA records be turned over to him by today.

Simultaneously, the Department of Health, Education and Welfare has begun its own investigation into the embattled drug institute, which it is supposed to supervise. An HEW spokesman told us that Secretary Joseph A. Califano Jr. "has an active interest" in the investigation. "It was done with his approval."

In our series, we documented how NIDA has blossomed into a closely-knit, chummy agency where friends, relatives, husbands and wives share in the federal largess.

The institute's $260-million budget is supposed to help Americans struggling with devastating drug problems. But much of the money has been wasted on bureaucratic boondoggles, our associates Valerie Strauss and Howie Kurtz discovered. Top agency chief- ins, led by Director Robert DuPont, end much of their time flying to ces like Rome, Geneva and Ho- lu to give speeches at drug con er- [illegible] ons of dollars have been ladled out on irrelevant research projects, including a $174,000 study of the sociocultural aspects of marijuana use among the Zulus of South Africa. Agency computers have been used to run an office football pool.

Although the House subcommittee would not discuss its inquiry, we have obtained from other sources a copy of the confidential letter that Moss fired off to DuPont. The congressman enclosed our columns and demanded an accounting of all NIDA research projects over the last three years, as well as a list of all consultants hired by the institute. Moss also asked DuPont to respond to the following allegations:

- That Mary Lou Dogoloff, wife of White House adviser Lee Dogoloff, "was employed by consulting firms that had contracts with NIDA while Lee Dogoloff was director of community assistance at NIDA."
- That "Lee Dogoloff and others at NIDA have used their position to influence improperly the awarding of NIDA contracts and grants to the consulting firm, Richard Katon and Associates."
- That "Richard Katon . . . has reviewed confidential NIDA contract information prior to the awarding of the contract."
- That "Laurence Carroll, director of resource development at NIDA, and his wife, Guinevieve, have been or are principal officers of a consulting firm . . . that has received funds" from NIDA.
- That "the consulting firm Macro Systems Inc. offered Frederick Harrison . . . a job as a consultant at the same time Mr. Harrison was on the review board that was awarding the contract."
- That NIDA official William Spillane "hired a personal friend, Paul Ryser, as a consultant to work with his division after the Civil Service Commission had ruled that Mr. Ryser was not qualified."

Prominent Traffickers — Moises Torrijos, brother of Panama leader Omar Torrijos, is not the only high-level Latin American official who is involved in narcotics trafficking.

A special congressional committee on narcotics abuse and control found evidence that the State Department has actually impeded enforcement efforts for fear of offending corrupt Latin American officials. Of six countries visited by the committee chairman, Rep. Lester Wolff (D-N.Y.), only Chile was found to be making an earnest effort to halt narcotics peddling.

Wolff reported that in Ecuador "many instances of high-ranking government officials involved in cocaine trafficking have been reported and documented." He said high-ranking judges had been bought off to allow the illicit industry to flourish.

We can now name one of the Ecuadoran kingpins. Federal Drug Enforcement Administration files identify him as Francisco Adum-Adum, a prominent lawyer.

The confidential DEA report states that Adum-Adum is known to have "upper level" government contacts. Investigators found he used his political connections to achieve his dominant position in the smuggling operations.

"Experts" are as hooked on federal money as their clients are on drugs.

The Drug Abuse Hustle

by Howie Kurtz

Richard Nixon's overzealous use of the government's police powers against the spread of narcotics has discredited, at least for a while, the criminal approach to drug abuse. Nixon's attempt to sensationalize the heroin problem and then use wiretaps and no-knock raids to combat it is seen by some leading Nixonologists as the cornerstone of his larger effort to subvert civil liberties, culminating in Watergate.

The current conventional wisdom is that drug abuse is a problem not for criminal law enforcement but for mental health experts. The primary vehicle of this new approach is a new federal agency, created in 1973, called the National Institute on Drug Abuse. In five years, NIDA has blossomed into a $260-million operation, supporting a tight little network of "experts" on the mental-health approach to the drug abuse dilemma. Using taxpayers' money, the members of this fraternity take turns hiring one another to study, quantify, assist and evaluate drug abuse policy. These abuses of drug abuse dollars are not as dramatic as the illegal buggings and break-ins of the Nixon years, but they are far more typical of the federal government's recurring failure in dealing with pressing social problems.

A typical NIDA research project that caused a bit of a flap was to involve showing pornographic movies to subjects stoned on marijuana and measuring their responses. Unfortunately for those lining up for the experiment, Congress got wind of it and terminated the project. But similarly imaginative studies, reflecting the "mental health" approach to drug abuse, have slipped through unnoticed. For example, there was the $80,000 grant to measure how dope and alcohol affect a person's ability to recognize smiles, scowls and other facial expressions. Then there was the $363,000 study to find out whether pot smoking makes a person more susceptible to hypnosis. Researchers with grants from NIDA routinely roam the globe. One group examined the socio-cultural aspects of marijuana use among the Zulus of South Africa. The expedition cost the taxpayers $174,000. Later a team of scientists was off to North Yemen, spending $275,000 to study a stimulant obtained by chewing leaves found only in that country. Other ventures have probed the anthropological significance of hashish use in Greek villages and pot smoking in Costa Rica.

A research rationale is not even necessary in order to see the world on government travel vouchers. During the past year NIDA's director, Robert DuPont, has visited Bangkok, Geneva, Honolulu, London, Miami, Denver, Houston, Montreal, Nigeria, Paris, Puerto Rico and Rome. The official purpose of these trips was to deliver speeches at various drug conventions. A casual reading of these addresses—available in the plush waiting room outside DuPont's office at NIDA headquarters in Rockville, Maryland—indicates that

The New American Hustlers

[illegible] American [illegible] entrepreneurs differ from their predecessors—founders of retail or manufacturing enterprises—in three ways. First, they tend to be selling a product that is more amorphous [illegible] ephemeral [illegible] downright mysterious—and several steps removed from the production of goods and services [illegible] the national prosperity. Second, they [illegible] existence of a large government [illegible] customer or as a generator of [illegible] product. And third, unlike traditional business [illegible] they tend to be enthusiastic believers in [illegible] government [illegible] which their prosperity [illegible]

Howie Kurtz works for Jack Anderson. *Valerie Strauss* contributed some of the research used in this article.

they are different variations on the same basic speech.

When critics call NIDA's cozy circle of bureaucrats "the family," they are not always being metaphorical. Consider the case of Lee Dogoloff, a NIDA official who has now moved over to the White House as a drug adviser to President Carter. While Dogoloff was at NIDA, his wife, Mary Lou, was paid about $17,000 by a Rochester, NY firm called BRX to work on a NIDA-sponsored study of drug abuse treatment programs in rural areas. She also collected at least $7200 on another NIDA contract from a Maryland firm named Macro Systems Inc. Its mission was to update drug treatment manuals used by NIDA program officials. Dogoloff insists he had nothing to do with her hiring. "I cannot control what contractors may do," he said, "but my wife is a respected professional independently." Dogoloff himself hired his wife to accompany him to an official conference in Thailand. He paid for her plane ticket, but the government footed the bill for her salary and expenses. Her job was to "prepare seminar logistics" or, more plainly, to take notes.

Dogoloff met his wife in the early 1970s when she worked as his assistant in a narcotics treatment program in Washington, financed by the District of Columbia government. The director of this program was Robert DuPont, now director of NIDA. Another official in the program was Dr. Richard Katon, who was close to both the Dogoloffs and DuPont. The four of them have been picking the fruit of the drug abuse tree ever since. DuPont became the head of a special drug office in the Nixon White House, which evolved into NIDA in 1973. Lee Dogoloff was named a top official in the new drug agency. Richard Katon put aside a career as a medical doctor to form a private consulting firm, which soon began winning various NIDA contracts. (The firm's original name was Addiction Consultation and Evaluation Inc., but he later changed it to Richard Katon and Associates). Mary Lou Dogoloff—whose chief qualification as a drug abuse expert is a BA in English—joined Katon's firm. As it turned out, Lee Dogoloff began supervising Katon's first contract with NIDA. He even signed a couple of work orders for his wife after they were married. She resigned from the Katon firm soon afterward to avoid such blatant conflicts, but Katon later hired her to write a couple of NIDA contract proposals.

More recently, a NIDA official tried to hire Mrs. Dogoloff as a $100-a-day consultant to rewrite a report that she herself had once prepared while working for another NIDA contractor. The report was entitled "Promising Approaches and Models for the Prevention and Treatment of Drug Abuse in Non-Urban Areas." The NIDA official who submitted her name was Barry Brown, who used to work for Dogoloff at the Washington narcotics program. The NIDA personnel office rejected the request three times as a waste of money.

Laurence Carroll, another top NIDA official, and his wife, Guinevieve, were principal stockholders in a Miami consulting firm called Social Systems, Inc. Carroll founded the firm, he says, to halt the exodus of mental health professionals from the Miami area. At least four states have funneled NIDA funds into this company. Florida, for example, gave Social Systems, Inc., $40,000 to run a drug training program. The state of Nebraska hired Carroll's wife as a consultant and paid her with federal funds to help set up a peer counseling program in its high schools. Carroll insists, however, that Social Systems never paid him a dime and that there is no longer any connection between the firm and his family. Last July, while on an official trip to Miami, Carroll met with a University of Miami professor and discussed a possible future job at the school. Four months later, the NIDA division that Carroll heads awarded $200,000 in grants to the professor's department. The assignment was to devise "informational systems for managers in an integrated health care network."

NIDA contracts are awarded by supposedly impartial review boards, but since the board members are drawn from the same small pool of "experts," total impartiality is often difficult. For example, Macro Systems Inc.—not to be confused with Social Systems, Inc.—once offered Frederick Harrison a consulting job on a NIDA contract for which it was bidding. This was another in a seemingly endless series of "technical assistance" contracts to aid drug abuse programs. It turned out that Harrison was on the review board that was awarding the contract. Harrison claimed he had been unaware of Macro's job offer, which was quickly withdrawn, but he remained on the review board anyway. Macro won the contract with top marks from Harrison for "excellent staff selection."

Friendship can be almost as useful a credential as marriage when the drug abuse bureaucracy is looking for experts. William Spillane, for instance, tried to arrange a high-paying post for his college chum, Paul Ryser, who once wrote a book with him. When the Civil Service Commission ruled that Ryser wasn't qualified, Spillane hired him anyway as a consultant. Ryser later quit NIDA to work for Richard Katon and Associates, which began winning fat contracts from Spillane's division. For example, Katon won a $78,000 contract to "develop NIDA statistical publications." He also won an $800,000 contract for "Drug Abuse Management Information Technical Assistance." Spillane was a member of the review board that awarded each contract. Last year, Katon won the information contract again, but the cost jumped to $1 million.

The network extends to the House Narcotics Committee, which is supposed to oversee NIDA. The committee's chief counsel, Joseph Nellis, says he doesn't have enough staff to properly check out allegations that NIDA is wasting taxpayers' money. Maybe he can get his wife to help. Last year NIDA awarded a $150,000 contract to Muriel Nellis. For this money she is supposed to assemble a "national coalition on women's issues in substances abuse." This included tasks such as preparing "guideline packages for each regional coalition to coordinate planning and strategy for resource identification."

The close relationships between those who deal out these goodies and those who get them should not obscure the basic fact that most of these consulting contracts aren't worth the requisition forms they are printed on. They are a form of white-collar welfare that has made consulting for the government a boom industry. Take, for example, the TRIPS contract, an acronym for Treatment Referral Information and Placement Service. This involves keeping track of drug "clients" as they move from one NIDA clinic to another. It is a glorified answering service. The $150,000 contract recently was awarded to Birch and Davis, a new firm founded by two men who saw the unlimited potential in consulting when they worked for the large and successful Macro Systems Inc. They split off to form their own outfit and now offer accounting and financial management services to federal agencies and private health groups, as well as design management information systems. They also are a minority firm that qualifies for special so-called 8 (a) contracts set aside for minorities without competitive bidding. (See "Capitalism Without Tears" by Stephen Chapman, *TNR*, April 1.) One member of Birch and Davis is Rebecca Rubenstein, who used to write academic papers together with Robert DuPont and Richard Katon as a member of the Washington drug program that has spawned so many drug abuse superstars.

Then there is the CODAP contract. NIDA is big on acronyms; this one stands for Client Oriented Data Acquisition Project. This one-million-dollar plum is for compiling statistics on drug users, their problems and their treatment at NIDA clinics. Unfortunately, the numbers frequently don't jibe with reality and the jumbled picture they present is of little value in helping drug users. But the staff at every NIDA clinic has to spend an inordinate amount of time filling out the computerized forms. In fact, they often have to be trained to fill out the forms by still more paid experts. NIDA recently paid the Macro firm $96,000 to write "a procedural manual for program experts." Whatever that is exactly, HEW already had one, so Macro simply took that manual and rewrote parts of it. Macro employs over 100 people to provide "technical assistance" in management, health care, computer systems and other areas to private and governmental clients. It has been remarkably successful at NIDA, even winning applied scientific research contracts that generally go to scientists at universities.

What do all these consulting contracts add to solving the problem of drug abuse? Even accepting the proposition that drug abuse is best treated as a mental health problem, the millions spent on these contracts do a lot for the financial health of a small group of prosperous hustlers and nothing directly for the mental health of drug abusers. In fact, one easily gets the impression that many NIDA officials and consultants never have seen a drug addict. All they talk about is "data acquisition" and "treatment modalities." The plain truth is that the average college student knows more about drug abuse on the street than the NIDA professionals.

This was graphically demonstrated when NIDA failed to detect the rapid spread of a popular but extremely dangerous animal tranquilizer called PCP. The agency's elaborate Drug Abuse Warning Network (DAWN), which gathers data from emergency rooms and clinics across the country, did not spot the upsurge in illnesses and deaths caused by PCP until the drug already was making headlines in 39 states. The DAWN reports are thick as phone books and generally regarded by drug workers as a joke. Only recently has NIDA commissioned some new studies of PCP, turning to Birch and Davis to investigate the deadly tranquilizer for $138,000.

NIDA does spend some money on actually trying to avoid drug abuse. But it's possible to question how effectively this money is being spent. NIDA Director DuPont, for example, believes that pot smokers should not go to jail, a position endorsed by President Carter and the 10 states that have decriminalized marijuana use. Yet he is spending 15 percent of NIDA's treatment funds on an effort to convince millions of people not to smoke marijuana. "We treat their problems," DuPont solemnly insists. "It sounds surprising, but there are people who can't stop using it, or who are having problems with their parents." It is little wonder that the government has no credibility among young drug users, even when it tries to warn about really dangerous drugs such as PCP. NIDA spends 60 percent of its treatment budget on the fewer than 500,000 heroin users in the nation. Yet it devotes only five percent of its money to the more than five million people who abuse barbiturates, which are responsible for far more injuries and deaths. Apparently, heroin addiction is the more politically attractive problem, associated in the public mind with street crime.

In its preoccupation with marijuana and heroin, the agency has ignored the little pills, both legal and illegal—such as Valium, Seconal, Quaaludes and Dexedrine—that cause far more harm to millions of Americans. These drugs are cheap, readily available, and regularly abused by businessmen, students and housewives. They are not very different from the instant remedies advertised on television. Of course there is not much political mileage in taking on the drugs that much of middle-class America abuses. Moreover, these drugs are produced by large, influential corporations that would not welcome a federal assault on their products. But it is the teenager who swallows a handful of Valiums at a party, guzzles some tequila and takes a few barbiturates who most frequently ends up in a hospital emergency room for drug-related reasons.

Allegations of NIDA's excesses have sparked two investigations, one by the House Subcommittee on Oversight and Investigation, the other by inspectors for HEW Secretary Joseph Califano. What these investigators will find, if they look beyond the blatant conflicts of interest, is a growing band of academic experts, armed with the latest jargon, who are becoming as hooked on federal dollars as their clients are on dangerous drugs; and yet another social problem that has generated an expensive federal officialdom, without any apparent hope that the officialdom has generated a solution.

Doctor in the House

From the start, Dr. Peter Bourne was the odd fellow among Jimmy Carter's Georgians—a suave Briton with a U accent, a drawing-room manner, a wall's worth of diplomas (in psychiatry and anthropology) and a self-possessed, socially conscious wife. For a time, he seemed the odd man out as well, banished to a windowless office in the White House basement with a portfolio of do-good projects that no one else actively lusted after. But the doctor, at 38, has endured his exile downstairs and has quietly turned it into a center of bustling, Bourne-again influence on issues ranging from marijuana to mental health—all on the accurate presumption that somebody upstairs still likes him.

Karl Schumacher—The White House

Bourne with HEW's Joseph Califano: Odd man in

That somebody is the President himself; Bourne was the first person to suggest that Carter seek the Presidency, and when he talks, the boss still listens. He helped persuade Carter to push national-health insurance onto the front burner, against the resistance of most of his senior advisers. He set up a mental-health commission for Rosalynn. He has been Carter's point man in efforts to ease penalties for smoking pot and stiffen the war on heroin smuggling. He has dabbled widely in diplomacy as Carter's official liaison with U.N. health and welfare agencies and as unofficial advocate of increased aid to underdeveloped countries. He can see the President "anytime I want to," he says, and sends him frequent memos. "In the areas he's responsible for," says Hamilton Jordan, "Peter has great influence on the President."

They made an odd couple from the day they met in 1969; Carter was a country conservative running for governor of Georgia, Bourne an urbane liberal-cause man (civil rights, antiwar, pro-abortion) directing a mental-health center in an Atlanta ghetto. But both Carters visited his center, liked his work and—once in office—recruited him to organize a mental-health project for Rosalynn and a widely praised drug-abuse program for the governor. The admiration was mutual. On a plane ride in 1971, Bourne asked Carter if he had ever thought of trying for the White House. "No, I haven't," Carter replied, "but if I did, this is what I would do"—a prelude to a detailed five-minute run-through of a battle plan he had plainly been thinking about for some time.

Limelight: When Carter sealed his decision the following year, Bourne found himself posted to Washington, where he took a job as a drug-abuse expert in the Nixon White House—and, with his second wife, Mary King, moonlighted as Carter's emissary to a chary Capital Establishment. Bourne in this role was all wit, polish and reassurance; King, a picture of elegance in large rings, laminar make-up and top-of-the-line couture. Their act played well in Washington and badly at Atlanta campaign headquarters, which suspected them of enjoying the attention of the press and the power elite rather too much. Merely being in Washington placed Bourne "in the realm of what we were running against," he says now, and led inevitably to talk down home. "Peter's always liked the limelight," one associate grumbled, "and Mary made him like it even more."

Their eclipse followed, and might have been total except for their own gifts of survival and Carter's kind regard for them. Bourne largely disappeared from the 1976 fall campaign, assigned, it was said, to write the official history of Carter's quest. After Inauguration, he and Ms. King were given handsome titles and wages—$51,000 for him as special assistant to the President, $50,000 for her as ACTION deputy director in charge of the Peace Corps. But she had hoped to be director, and he found himself cut out of Carter's inner political circle. Bourne survived by carving out his own four-point brief (mental health, drug abuse, world health, world "human needs") and selling it to the President—an effort in which Rosalynn's coincident interests may have helped. "Peter," says a colleague, "can make the President look good on issues Rosalynn cares about, which is not to be underestimated."

Neither are Bourne's own reserves of talent, energy and ambition. With Rosalynn's mental-health commission and his own drug-abuse program safely on track, he has begun broadening his sphere of influence. He urged a start on health insurance, arguing in an apparently persuasive dear-boss memo that it would be a way for Carter to leave his mark on the Presidency. He jollied a President who doesn't like commissions into awarding him two more, on world hunger and the International Year of the Child. He has created his own one-man embassy to everywhere—to New York and Geneva on U.N. business, to the Third World on his pet health projects—and has occasionally bumped heads with Carter's turf-conscious national-security adviser Zbigniew Brzezinski in the process.

'He Talks Funny': It is still sourly remarked by the men upstairs that the man downstairs favors tailored suiting, vintage wines, admiring notices and the tinkly crystal glitter of Georgetown. But Bourne remains a charter Georgian —"He just *talks* funny," kids Jody Powell—and as such has a claim on that band-of-brothers loyalty Carter has lavished even on Bert Lance. If he works belowstairs now, he nevertheless sits surrounded by pictures of Carter in repose—the talismans of his position at court. And if he has settled too comfortably into the good life Washington style, that did not deter the Carters themselves from slipping over unannounced one evening last month for five *intime* hours of dinner and table talk—evidence enough that Carter remains interested in what Peter Bourne has to say.

66

Dr. DuPont. By the same reporter. This remains a one reporter story, Mr. Chairman. Thank heavens.

Senator Hathaway. Could you give us your general evaluation of the credibility or truth or veracity of these articles?

Dr. DuPont. I think if you sat back far enough, it is possible for me, the attackee, to see some point to the article. The general function of the press as being a gadfly, and making people come forward and justify what they are doing, and talking about the fact that the Government has embarked on a very expensive operation in the drug abuse area and that we have not solved the drug abuse problem. I thought the New Republic article probably gave it a more philosophical kind of justification for the attacks than anything I had seen. It seems a little bit sophomoric. What it essentially says is any time the Government tries to solve a problem, it creates a program. There are people who run the program and those people receive certain benefits, including a salary, from the program and somehow the implication is that is wrong.

I do not follow the last step. At least the first two steps, it makes some sense.

With respect to specific charges, I have been very distressed by those. I think they are, at least as I have been able to determine, groundless and based on innuendo and are very misleading. They would lead the reader to believe that these are new charges generated by some investigation that Mr. Anderson's reporters carried on, when in most cases they are simply a compilation of old accusations and rumors that are hanging around. In most cases they have been dispersed of in a way that Mr. Anderson and his reporters know about.

Just to give you one example. Talk about NIDA computers being used for football or baseball pools, some kind of game that was going on in our staff, is true, this did happen. This was an erroneous use of the computers. It went on one time. The staff was reprimanded for this. The total cost to the Government to activity was $1.59. Now if Mr. Anderson had said that this was a one-time affair that went on, that the staff was reprimanded about it, and the total cost to the Government was $1.59, I would not have a quarrel. But he leads one to the conclusion, the reader to the conclusion that this is a regular and very costly to the taxpayer kind of activity.

Similarly the charges with relationship to Mr. Dogoloff were charges that were brought to the attention of the Senate at the time of his confirmation, and were investigated by the Federal Bureau of Investigation thoroughly, and after the Senate had the access to this information—in fact, his confirmation was held up to allow completion of that investigation—there was no wrongdoing found, and he was confirmed without opposition.

Now it seems to me Mr. Anderson might have told his readers that these charges did involve several years ago; that they were investigated by the FBI; and that no wrongdoing was found by the Senate. Now that information was simply not given to the reader. The reader was left with the impression that this was a new charge.

Similarly in the research area, Senator Proxmire did some original research of his own and found five of our research projects he found laughable, wasteful, and he gave us the Golden Fleece award 3 years ago. Mr. Anderson finds the same release and gives the same account of the same research projects and held us up to the same ridicule that Senator Proxmire had a couple of years ago, with no indication that we went through the same process, that this represents direct plagiarism. He does not credit Senator Proxmire for having beaten us on that subject 2 years ago.

It seems to us each of the cases that comes up, he takes offense at my travel. I do not understand what the standard is for my travel that he finds offensive. I bet I am in town more than Mr. Anderson is. I do not travel a lot. I was in the office 80 percent of the time last year, not traveling a great deal, although I think it is important for me to travel from time to time. He would lead the reader to believe I am never in my office, that I am always out.

I made one mistake talking to his reporter. I was feeling sorry for myself about travel. I came back from a trip, and was tired when I talked to the reporter. He made me seem I was griping about what was to the average reader a tremendous advantage. I must say for me over the last couple years, travel rather than being something I yearn for, I really prefer to stay in my office most of the time. That did not sound very good when I was griping about this marvellous opportunity I have to travel.

It is those things I have found very painful about the Anderson charges. It has been very difficult for me to have an opportunity, to have some kind of opportunity to set the record straight that is not purely on the basis of my own self-interest, my credibility. When one is attacked, as you know very well, anything one says in one's defense is discounted because of the clear example of self-interest.

In this regard I have great hopes that the Inspector General's investigation that is now going on will lead to a public report. My fear is frankly that it will not; that this will find that quarterly reports were not found on 13 grants in the last 3 years, and there was some technical deficiency in this or that or other thing, and then the report will go on, and there will never be issued a report. I am hopeful, and I hope this committee can be helpful, in issuing some kind of statement that these charges have been looked into and here is the result of this. We now have 10 people full-time working in NIDA investigating Mr. Anderson's charges. I think it would be very interesting to know how much taxpayers' money is being expended to investigate the charges of one reporter, and to find out at the end what benefits accrued from that investment.

But that is a personal editorial comment.

Senator HATHAWAY. Do you know when the Inspector General's investigation will be completed?

Dr. KLERMAN. The Department initiated a formal investigation of those charges, the investigation is underway, we hope they will be finished within the next 6 weeks. We cannot state with assurance.

Senator HATHAWAY. The Inspector General is investigating all the questions that have been raised by Anderson and others?

Dr. KLERMAN. Yes. I am not privy to how that group functions. They follow whatever they feel might be something that should be looked into, as much to ascertain and assure Congress and others that there is no wrongdoing within the areas identified: travel, personal activities, and issuance of contracts.

Dr. DuPont. They are investigating far more widely than just the Anderson allegations. They are going through the entire organization with a fine-tooth comb. This I welcome. I have no objection. It is an extremely thorough investigation.

Senator Hathaway. They are going to file a written report, I presume, when it is through. There is no reason why it should not be made public, is there?

Dr. Klerman. Yes, sir.

Senator Hathaway. Now I think you answered most of these questions. You say there was no favoritism given to spouses of various friends of NIDA?

Dr. DuPont. That is right. There is none. In fact I meant to mention, one of the most offensive aspects of these charges is what I think can best be thought of as sexism involved in the charge; the presumption because two people are married, that the wife must be a pawn in some kind of activity that the husband is carrying on.

Now the four examples that were talked about were all where there was a husband and wife relationship. At no point was the husband involved in making an award to the wife. That is for certain. At no point were any departmental regulations involved and conflict of interest violated that we have looked into. There is no question about it. But the implication that these women, simply because they are doing business in the field that their husbands are involved in, is somehow in itself wrongdoing, I find that to be extremely offensive, and a sexist charge. These women are professional women who have credentials on their own and who have secured these contracts entirely on the basis of their merit.

Again Lee Dogoloff is a good example. His wife was involved in drug abuse activities as a professional before either Mr. Dogoloff or myself got involved in the field in 1967. She is well respected in her own right. To view her as some kind of extension of him in terms of the field is just to misread the facts.

Senator Hathaway. They received grants from NIDA?

Dr. DuPont. She did not. She received a subcontract award from a NIDA contractor, in fact the work on the rural drug project, and I think, others.

Senator Hathaway. Did you have any control over who would get a drug contract?

Dr. DuPont. No; and there is no reason she should not do that. It was not Mr. Dogoloff's division. He is in charge of the Community Services Division. This was let by another division.

I would be happy to submit for the record, we have prepared responses to each of these individually. I think in summary it is fair to say we have found no examples where spouses received favorable treatment or any conflict of interest violation exists on the basis of spouses' activity.

Senator Hathaway. How about the allegation that some individual received confidential information regarding contracts prior to their award?

Dr. DuPont. As far as I know, there is nothing to that at all, either. The one allegation had to do with the fact, that I remember, was that Mr. Caton was in the Contracts Office at the time he should not have been there and was asked to leave. It is true, and again I am glad to have the opportunity to say this, NIDA does have a very large contract operation and a very small and overworked staff. We also have what we consider to be inadequate space, there is no space for contractors to have waiting room or a place they can sit or wait for an appointment with somebody that is not in their office. That can be a problem. We know of no example where Mr. Caton or any other contractor received access to confidential information.

Senator HATHAWAY. What about the allegation of training center grants that may have been awarded to firms that were friendly to NIDA despite the presence of lower bids or alternative lower bids? This is the University of Miami.

Dr. DUPONT. There is nothing to that. Did this relate to the most recent training center award? I think this is what this relates to.

Senator HATHAWAY. Two years ago.

Dr. DUPONT. It was not recent?

Senator HATHAWAY. Three years ago.

Dr. DUPONT. No, I do not know about that specific case. I would have to submit that for the record.

Senator HATHAWAY. Could you check that out?

Dr. DUPONT. Yes.

Senator HATHAWAY. How about the allegation that NIDA employees may have been downgraded due to their involvement providing information to outside sources regarding alleged abuses?

Dr. DUPONT. I am glad you asked that question. That is my favorite question.

The idea that the Director or anybody at NIDA would downgrade an employee because of any activity, including insubordination or going to the reporters or saying things we do not like is so laughable on the face of it. No time in 4½ years of NIDA has any employee been downgraded because of any activity on the part of NIDA management whatsoever. As you know, the civil service regulations are so incredibly difficult to downgrade anybody for any reason, whether I like them or do not like them or anything else, the fact is nobody has been downgraded. There are several proposals for downgrading in NIDA, however. All of them have been initiated by the Department of HEW's personnel audit and review, and in every case I have appealed the downgrading. In other words, I have tried to obtain for the employee his status. We do not have to look into this one very far to find there has not been a downgrading for any reason, including this one, in the last 4½ years.

Senator HATHAWAY. With respect to the New Republic's allegation, I understand that their allegation was really with respect to waste and I suppose it is a matter of opinion. They mentioned that with respect to data collection. Could you describe the basic data sources utilized by NIDA?

Dr. DUPONT. Yes, the main data source on our treatment population is the KODAP system, which involved an admission report on every client, and a monthly summary of the number of patients in treatment in the programs. This is a very modest reporting system in the sense that it is only a one-page admission form and one-page discharge form on every patient taking 10 minutes or so for the program to complete it. We do not think it is onerous at all. It has been very helpful to us in terms of monitoring drug abuse problems and also performance of the programs.

Several years ago we had a very serious problem in this country where the heroin problem was getting worse, and our budget was held the same or even was shrinking. The problem was how to get the most effect from our treatment dollar in terms of the most serious drug problems in the country. One of the things we did was, through the KODAP system, identify that there were at the time I think around 7 percent of the treatment capacity in the country was providing essentially mental health services to people who did not have a specific drug problem; another 15 percent were people using marihuana only occasionally and had no other drug problem; and around 7 percent had a problem with alcohol, but no drug problem whatsoever. On the basis of KODAP data, we went to each program and got them to retarget their attentions on to serious drug problems, not just heroin, but any drug problem that was a serious kind, and solely done on the basis of KODAP data—we recouped more money in terms of effectively dealing with the drug problem than the entire cost and development for 5 years of the KODAP system.

That system has proven very useful. As a matter of fact it is now being looked at by other institutes as a model for client management data.

Senator HATHAWAY. Well, I have got some other questions in that regard on these various allegations, that I hope you will answer for the record. I think you have answered the generic one, anyway. We will have the Inspector General's report and hopefully we will clear up and finalize this matter.

Let me ask you something in regard to what has happened since ODAP has gone out the first of April. What in your opinion has been the working relationship since that time? Has it differed to what the relationship was—the structure was when ODAP was in effect?

Dr. DUPONT. Yes, I will be happy to. Let me back up a little to say something on what you were talking about earlier, and also about the relationship to HEW in general. I think we need to recognize the fact that Dr. Klerman and the Secretary are new to this field, to their post within the last year or so, and that HEW has always been the kind of odd organization out in drug abuse policy. We have had a real problem right from the beginning. The reason the Special Action Office was created in 1972 was because of the failures in HEW to respond adequately to treatment aspects of drug abuse prevention activities. You remember the legislation only related to the so-called demand reduction side because of these problems. The difficulty, I think, is primarily structural and it does not have to do with who is the Secretary; it is a structural problem. In contrast in the State Department, Customs Service, DEA, in each of those organizations the head of the organization is a relatively high-level individual in the organization who has direct access to the Secretary. NIDA's position as a fourth-level bureaucracy does not have that kind of access. In HEW, there is constant presure to keep drug abuse in line with other health priorities, which I am completely supportive of. This puts tremendous strain on policymaking activities, the Secretary's kind of activity, and leads to I think a kind of reinforcement of the concept of having separation of the drug and alcohol, the kind of thinking going on here.

I feel very optimistic about this evolution going on right now, and about teamwork that has been established between Mr. Califano and Dr. Klerman, in taking the leadership.

Identification of Dr. Klerman and Mr. Meltzer to take on for the Secretary in this is a rather constructive step, although it has come after a rather painful series of misunderstandings and struggles within the executive branch of Government.

With respect to ODAP, it is very important to realize that President Carter, when he was first Governor of Georgia, took special interest in drug abuse in 1971 and has very active interest personally in this. He has a special relationship with Peter Bourne. My own judgment is, Dr. Bourne said this, perhaps it has more to do with the people than it does with the law. The fact is that Dr. Bourne has a direct relationship with the President, and the fact is that Dr. Bourne is very knowledgeable, uniquely so, I think, of the drug field, and for that matter, the alcohol field. The fact of the matter is there has been no change in the coordination now that ODAP is out of existence. Everything is going on as before. My presumption is that Dr. Bournes leverage in dealing with various bureaucracies, including HEW, and so forth, will remain intact as long as he is there and has the relationship he has with the President. I think the reason for having ODAP would be, not that it is failing now, I do not think it is failing now, but what happens when the players change?

If the players were to change in the absence of a legislative authority, I think then the whole thing could crumble absolutely, and there would be nothing left of Presidential authority in this area. Right now it is working very well.

You might be interested, Mr. Chairman, in something I came across recently; that is, this Presidential assistant for Drug Abuse Policy was a recommendation of the John Kennedy Drug Abuse Commission in 1963, which I think is very interesting that even in that year, in 1963, when drug abuse policy for the Government was reviewed, one of the first two recommendations made by that Commission was that there needed to be a Presidential assistant to coordinate all of the drug abuse policy if the Federal Government was to have a coherent policy of dealing with the drug abuse problem. It took over a decade or nearly a decade for that to be implemented.

I think it is a very important principle. Right now it is going along very nicely. As Dr. Bourne said, those meetings are continuing, just as they were before. I feel very confident of this coordination and leadership.

Senator HATHAWAY. One last question. Would you tell us what the difference is between urban and rural areas in the nature and extent of drug abuse? Is there anything peculiar to different areas that makes the problem different?

Dr. DUPONT. Yes; I think there are differences. I do not think we have done as well as we should in addressing those differences. I welcome personally the suggestion in the legislation that we would issue a report about these differences and also give you some idea what our plans are to improve our performance with respect to rural areas. In general, the rural areas have lower incidences of drug abuse than urban areas by about 50 percent in illicit drug areas. Unfortunately in the past, I think this has led people to believe rural areas do not have a problem. This is wrong. Rural areas do have a problem. Urban-rural differences are diminishing over time.

The problem has been our basic treatment approach is based on clinics for drug abusers. There is not a sufficient concentration of drug abusers in rural areas to have that be a viable approach to the problem. So it has been difficult for us to think through conceptually how to deliver the services in a way that is appropriate and economical in the rural areas. This is an example, I think, where partnership with the States can be very helpful.

We anticipate though that our drug abuse activities will have to be integrated with other health services in rural areas in a way that they are not generally in the urban areas, and perhaps ironically for many people in urban areas, although you would appreciate this very well, in the end I think 10 years from now we are going to look back and say integration that was pioneered in rural areas led the way to the integration that was needed and can be useful in the urban areas in drug abuse policy and programing. So I see that as a need and I welcome the opportunity to address it more fully.

Senator **Hathaway**. It seems your testimony opposes any earmarking that Congressman Rogers' bill and my bill has for prevention activities.

Dr. **Klerman**. The position is that research and demonstration projects are an important part of the drug abuse program, along with training and treatment and rehabilitation. The administration feels that there is adequate provision for the support of those programs under existing authorization and does not feel a separate authorization is necessary. We do not question the necessity and desirability of programs in prevention, adequately researched and validated.

Senator **Hathaway**. You just do not want to earmark it?

Dr. **Klerman**. We would prefer not to.

Senator **Hathaway**. Let me ask you both some questions with regard to the general area of research.

What research is going on now and what activities and do you think it enough? It always seems to me we do not put enough research on either alcohol or drug abuse. Money that goes into prevention is probably wasted until such time as we get adequate research to tell us what direction we ought to go. Do you agree with that?

Dr. **DuPont**. I think we have invested inadequately in research. The fiscal 1979 budget reverses a downward trend in research investment, and is probably the proudest achievement from my point of view of this administration in terms of the drug and alcohol area, mental health area.

I welcome this and I am very grateful for this. It will enable us to pursue very vital new areas of research activity in the next year, including, for example, research on phencyclidine, which is a new drug problem about which we know very, very little; as well as more basic research, for example, in the endorphin field, the body's morphinelike substances in the brain, which has great promise for treatment and understanding the function of brain and feelings.

We are very optimistic, and we think it is overdue. As Dr. Klerman says, we hope next year also we can show another increase.

I would like to say publicly how appreciative I am of the leadership of Dr. Klerman and the Secretary in helping us to arrange for movement of an addiction research center from Lexington, Ky., to Baltimore, which will mean our intramural research will be able to make a major new contribution in the research field.

Senator **Hathaway**. Dr. Klerman, do you have anything?

Dr. **Klerman**. We are pleased that there has been a turnaround in the recommendations of the administration. There are additional funds for research in alcoholism, drug abuse, as well as mental health. I would have to say in response to your question, I think there is still a major gap between the great need—the gap is greatest in alcoholism, but it still exists in drug abuse and mental health.

Senator **Hathaway**. It seems to me from a list of research projects that we have that, we are proliferating our effort too much. Should we just concentrate in certain areas and not look into depression effects from heroin addiction and other projects, which are probably worthwhile in and of themselves, but I just wonder if they have the highest priority, and whether we should not be taking most of the research money and putting it into prevention?

Dr. **DuPont**. We will increase our research investment in the prevention area from about $300,000 to nearly a million dollars in 1979, fiscal 1979. So we do agree that that is an area of increase. As Mr. Dogoloff mentioned, also NIDA's prevention money, our total budget in 1979 now stands at $5 million and is being used essentially as research money. We have retargeted our prevention program in the last 2 years from primarily a services program to primarily a knowledge development program.

We do think we make some movements in the direction you are talking about.

Senator **Hathaway**. How much more authorization do you think you really need to do a good job in research?

Dr. **DuPont**. Well, I think for 1979 the increase is adequate. We went from $34 million to $46 million in 1 year. I think that is plenty for that year. I think for 1980 is another question, and I would have to give some thought to it.

Senator **Hathaway**. Disregarding OMB budget restrictions, how much money would you like to have?

Dr. **DuPont**. For 1980? I think that is enough for 1979. I think that is plenty for an increase.

Senator **Hathaway**. You could not spend any more?

Dr. **DuPont**. We could spend a lot more money.

Senator **Hathaway**. Worthwhile projects. The amount of research in this area is nowhere near what is being spent on cancer and heart disease.

Dr. **DuPont**. I think it is important to have a gradual change in the budget. One of the difficulties we have, there is no increase in our research staff to go within roughly 20 percent in our budget, and if the budget were increased beyond that, I think the lacks in terms of our staff resources would be more deleterious. I think if I were to look at our budget for 1979 where deficiencies are. I think they are in prevention and demonstration, which is the thrust of our earmarking activities. I think our request for those is about $5 million more in each of those two areas than is currently requested. Other than those relative things, I think the NIDA budget is a very sound budget that we are very grateful for.

Senator **Hathaway**. Fine. Thank you. Thank you very much, both of you.

[The prepared statement of Dr. Klerman and material subsequently supplied for the record follows:]

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

TESTIMONY OF GERALD L. KLERMAN, M.D.

ADMINISTRATOR
Alcohol, Drug Abuse, and Mental Health Administration
Department of Health, Education, and Welfare

on Senate Bill S.2916

before the
Human Resources Committee
Subcommittee on Alcoholism and Drug Abuse
United States Senate

Wednesday, April 19, 1978
9:30 A.M.

Senator Hathaway and Members of the Subcommittee, I am delighted to be here today to present the views of the Department of Health, Education, and Welfare on S.2916, a bill to amend the Drug Abuse Office and Treatment Act of 1972 to extend the authorizations for programs of assistance under that Act for drug abuse prevention, education, treatment and rehabilitation for one year. These authorizations are to expire on September 30, 1978. I am accompanied today by Robert L. DuPont, M.D., Director of the National Institute on Drug Abuse.

The legislation introduced by Senator Hathaway on April 13, 1978, includes:

1. A one-year extension for fiscal year 1979 of section 409 of the Act, which provides for the drug abuse formula grant program, at the current dollar amount of $45 million;
2. A one-year extension of the programs authorized by section 410 of the Act for fiscal year 1979, under which drug abuse treatment and prevention activities are funded at a total level of $177 million, including a split authorization of $153 million for grants and contracts for drug abuse treatment and $24 million for prevention, demonstration, and other section 410 activities;
3. A one-year extension of section 503 of the Act to encourage support of pharmacological research programs at the current level of $7 million;

4. An expansion of the section 405(b) reporting requirement of the Act to require that the Secretary report each year by January 15 on the health consequences and extent of drug use in the United States and provide a description of activities within the Department of Health, Education, and Welfare that address the drug abuse problem; an evaluation of program effectiveness; a report on coordination within the Department and recommendations for implementing programs in the field; and proposals for changes in HEW's drug abuse activities, including recommendations for legislation;
5. A special one-time report on the problem of drug abuse in rural areas, to be submitted within 120 days of the enactment of the legislation;
6. A requirement that the NIDA Director, in carrying out the section 502 technical assistance authority, provide for the same type of assistance for drug abuse prevention programs as he now does for the control and treatment programs;
7. An amendment to provide assurance that State drug abuse agencies coordinate planning with local drug abuse planning agencies and with State and local health planning authorities and educational agencies;
8. A change in section 409(e) of the Act to require the submission of drug abuse State plans to the Secretary on July 31 of each year rather than July 15; and

9. A change in the current reporting requirement on marihuana and the public health contained in section 502 of the Marihuana and Health Reporting Act, from every year to every two years.

Mr. Chairman, with regard to most health authorizations expiring this year, the Administration has requested 3-year extensions. With respect to the drug abuse law, we would recommend such an extension and will be submitting legislation to this effect. However, we do recognize that there are several good reasons behind the proposal for a one-year extension of the drug abuse programs at this time.

While a great number of health authorities were given a one-year extension last year, drug abuse was not among them. Despite the fact that the sections expiring this year are 3-year authorizations, the 1976 amendments to Public Law 92-255 were, in fact, enacted over one year late in the legislative cycle, due to controversy over creation of the Office of Drug Abuse Policy. Thus, the amendments contained in that legislation have been in effect only for less than 2 years.

In addition, the Administration budget request for fiscal year 1979 is $40 million for section 409 and $161 million for section 410, rather than the levels contained in S.2916. We believe that a separate authorization for drug abuse prevention and demonstration activities is unnecessary since these activities can be carried out within the general section 410 authorities. In 1978, for example, $15 million will be spent on these activities under section 410.

S.2916 would expand the reporting requirement contained in section 3 of the bill, mandating the Secretary of HEW to report annually on the health consequences and extent of drug abuse and on the Department's drug abuse program activities, and to change the Marihuana and Health Report requirement from 1 to 2 years. However, we would strongly recommend that you go further with this proposal by consolidating the marihuana report into a biennial report on the health consequences of drug abuse. This recommendation is, in part, a reflection of our joint effort with the General Accounting Office to reduce the number of reports required by statute.

We share the Subcommittee's concern that the problems of drug abuse in rural areas be given appropriate attention, as reflected by the Subcommittee's wish to receive a special one-time report on drug abuse in rural areas and the amendment of section 303 of the Act to require inclusion in the Federal Drug Abuse Strategy of a mechanism to assure development of effective drug abuse prevention programs in both urban and rural areas. Over the last few years, the services research program of the National Institute on Drug Abuse (NIDA) has pursued a rural drug abuse initiative which has included two studies on the differences between rural and urban drug abusers, as well as the special concerns and problems of drug abuse program administrators in rural areas. These studies were published and disseminated to the field with models of program delivery structures particularly appropriate for rural areas recommended. Also, NIDA has amended its national household survey of drug abuse patterns to include an assessment of drug abuse in rural communities in comparison to urban centers. In addition, NIDA, in cooperation with the National Institute of Mental Health (NIMH) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is looking at the substance abuse problems of migrant workers. And finally, NIDA is encouraging proposals for demonstration grant assistance to test innovative ways for providing drug abuse services in rural communities.

The Department supports the objectives of the new technical assistance requirements of section 3(c) and has already accomplished much of its intent by administrative action. Similarly, section 5(a) of the bill emphasizes the importance of involving local drug abuse and health planning authorities in the preparation of the State drug abuse plans. NIDA has urged in the implementing regulations for section 409 that local officials be so involved. Although NIDA's treatment services funds are administered through the statewide services contract mechanism, we share the Committee's interest in assuring local government input.

Finally, we support the amendment of section 409(e) of the Act which changes the due date for submission of State drug abuse plans from July 15 to July 31 of each year. With this change the State drug and alcohol plans will now be submitted to Federal authorities on the same date. As often these plans are prepared by a State office having combined responsibilities for drug and alcohol abuse, this change should be very helpful to State authorities in simplifying the requirements for submission of materials to the Federal Government.

I recognize from the Chairman's comments at the introduction of this legislation the concern of the Subcommittee about the issue of Executive Branch coordination of the drug abuse program. I have examined this matter and feel confident that the mechanism the Administration has provided to continue policy coordination through the Domestic Policy Staff and a revitalized Strategy Council on Drug Abuse will be satisfactory to the Congress. I look forward to working with this new system of program coordination.

Mr. Chairman, I would like to commend you for your outstanding leadership in the field of drug abuse. I thank you for the opportunity to testify on S.2916 which we endorse, subject to changes identified above, and I will be pleased to answer whatever questions you or the other members of the Subcommittee might have at this time.

Question: Could you elaborate on the impacts which drug abuse has on our society in the following areas -- lost productivity, health costs, mortality, crime rates, with particular attention to violent crimes, and other related costs? Could you supply further detail on these matters and trends over the past 3 years?

Answer: NIDA periodically updates estimates of the social costs of drug abuse. Our current social cost study reflects costs for the year 1976. This recently completed study is under review by a panel of experts; we anticipate that it will become an official NIDA publication in the near future. Much of the material presented here is from that study and remains, as yet, unofficial. The attached figures show the total social costs of drug abuse for 1976 as being $16.7 billion. This figure is 38 percent higher than the $10.3 billion for the year 1975. After allowing for the inflation factor, the difference is probably largely due to an improved methodology rather than to any gross cost increase in the several categories.

Measures of foregone or lost productivity are the indirect costs of drug abuse. Indirect costs are a serious by-product of the non-medical use of drugs and a contributing factor to the total social costs of drug abuse. The indirect costs of drug abuse in 1976 were estimated to be $7,584.9 million. Of these, $5,021.6 million were due to unemployability and a reduced potential for labor market activities, $1,912.3 million were due to incarceration, and $651.0 million were due to premature death. Indirect costs were 45 percent of the total social costs of drug abuse for 1976.

The direct medical care costs of drug abuse as estimated for the nation for 1976 are:

	(Millions)
Inpatient Hospitalization	$799.5
Emergency Room Services	23.3
Outpatient Clinic Services	4.7
Inpatient Mental Health Services	48.9
Outpatient Mental Health Services	22.0
Total	$878.1

For about a year NIDA has been involved in a project designed to answer some very important questions about drug abusers and their demands on the health services delivery system:

(1) Do drug abusers have lengths of in-hospital stays which are longer than for their non-abusing counterparts?

(2) Do drug abusers use more medical resources per stay than their non-abusing counterparts?

(3) What percent of drug abusers seen in the emergency rooms are hospitalized compared to all emergency room users?

Some preliminary studies appear to indicate a relatively greater use of medical services by drug abusers, but we do not know whether this represents an overall increase in their use of medical care. There are some indications, in fact, that some medical complications seen in hospitalized drug abusers are the result of an earlier neglect of medical care, i.e., failure to use medical resources.

It should be pointed out that the figures listed above do not include the costs of visits to private physicians, visits to company physicians, school physicians, drug counselors, and a wide variety of medical and mental health providers who are not otherwise captured in our categories. Neither do our social cost studies provide estimates of the medical care costs of victims of drug abusers. Thus, medical care costs for categories such as damage to the newborn, child abuse and neglect, automobile and job-related accidents and injuries, and crime-related injuries are not included in our social cost estimates.

There are controversial assumptions underlying estimates of the social costs of crime due to drug abuse; assumptions about the extent of these costs tend to determine attitudes and policy toward drug abuse. Some researchers include the value of stolen goods as part of the social cost of drug abuse. Economists, however, tend to exclude the value of stolen property, pointing out that the value of stolen goods contains an involuntary transfer element which is not a cost to society. Including this involuntary transfer as part of the costs of crime not directly related to drug laws grossly over estimates the social costs in this category.

This does not mean that all crime costs are merely transfers. The psychic costs are likely to be one of the most important consequences of crime, although these are simply beyond conversion to dollar terms. In NIDA's current social cost study, consideration has been given to drug abusers in both legal and illegal markets, and estimates of the social costs of crime due to drug abuse are viewed as the value of the product that would have accrued had illegal "work" been converted to legal work.

TABLE A

Social Costs of Drug Abuse, 1976
(millions)

Direct Costs	
Medical Care	878.1
Law Enforcement	3051.1
Judicial System	1008.6
Corrections	1161.6
Prevention, Rehabilitation and Treatment	1134.9
Private Security	504.0
Private Legal Defense	45.1
Crime*	1376.1
Total Direct Costs	$9159.5
Indirect Costs	
Unemployability	5021.6
Incarceration	1912.3
Drug-deaths	651.0
Total Indirect Costs	$7584.9
Total Social Costs	$16744.4

* Does not include the value of stolen goods, which is seen as an involuntary transfer element and, as such, not a cost to society.

The social costs of crime due to drug abuse are the costs of drug-related violence and other criminal activities, broadly defined to include psychological effects and bodily harm. The 1976 study provides only an estimate of the costs of criminal activities as proxied by the amount of labor attributable to drug-related crime. It is, therefore, an under estimate. The estimate is based upon the assumption that all drugs of abuse may generate social costs and that in the nation in 1976 there were 770 thousand abusers whose criminal activities were due to the abuse of drugs -- 500 thousand opiate abusers and 270 thousand non-opiate abusers. They accounted for social costs of $1.3 billion.

(A recent independent estimate was based on the assumption that 19 percent of property crime was committed by 558,000 heroin users in 1974. Total cost of property crime committed by heroin users in 1974 was estimated to be $3.9 billion. As mentioned, this kind of figure is not included in NIDA's current social costs report.)

In response to the question about trends over the past 3 years, NIDA's four social cost studies reflect certain differences in assumptions, categories of cost, and methodology. In particular, each study improves the vigor of the methodology, and any apparent trends, therefore, would be comparable. Our current social cost study (fourth) is now being critically reviewed by a panel of experts. The major charge to the author and the review panel is to establish a sound methodology which will permit replication in subsequent social cost studies and against which we can make more valid observations about trends.

Question: What efforts are being made at the Federal level to eliminate these problems?

Answer: Three years ago NIDA stimulated and funded a pilot study for a supported work program to help our clients to accomplish the difficult transition from drug dependent clients to drug-free employees. Supported work emphasizes the placement of marginally employable individuals in low stress jobs, gradually increasing both performance demands and performance-related rewards as clients are prepared for the regular job market. The model for supported work for former drug abusers and other disadvantaged groups has spread to other sites across the country as a promising approach in helping clients secure employment. Over the past two years we have been moving to "institutionalize" vocational rehabilitation counseling and employment development techniques as an integral part of the treatment experience clients encounter in our programs. In preparation for this we have had underway for some months a controlled study that will identify for us the best measures for accomplishing that goal (i.e., adding a vocational rehabilitation/employment specialist to the treatment staff, or enabling staff to use the consultant services of such specialist from outside the treatment program). NIDA is also involved in developing a cooperative agreement with the Rehabilitation Services Administration. The agreement is intended to establish principles and procedures to formulate, coordinate, and integrate vocational rehabilitation and drug abuse treatment services.

In the meantime, last year NIDA prepared and distributed to all treatment programs a guide for Developing and Using a Vocational Training and Education Resource Manual. This guide was developed to help drug treatment program staff efficiently and effectively locate and utilize training and educational programs in the surrounding community.

Question: Could you supply further information for the record?

Answer: The unemployment experience of drug abusers is a complex social disability phenomenon which is sensitive to the capabilities of the individual drug abuser and the community employment picture. We believe that the unemployment of drug abusers is the single social cost category that has the greatest significance in both human and economic terms. We estimate that the cost in terms of foregone earnings for the year 1976 was over $5 billion, and the human costs in terms of loss of self-esteem and problems for the families are intangibles that cannot be measured. Around two-thirds of drug abuse treatment clients experience long-term employment - that is, a protracted period of unemployment that considerably exceeds the day or week or month immediately preceding admission to treatment. Drug abuse is a condition, a behavior, that intensifies the social cost of unemployment. It is also a condition that is intensified by a closed or stagnant job market.

Question: With regard to all treatment programs, to what degree are clients, after treatment, able to become part of the workforce, and to hold down jobs in the private sector? Could you supply such information for different treatment modalities?

Answer: The importance of employment in the drug abuse treatment and rehabilitative process, and techniques for improving employment opportunities for ex-drug abusers, are among NIDA's highest priorities. We view employment as essential to successful rehabilitation and consider employment-related assistance to be an appropriate function of treatment programs. The report from our treatment programs at the end of FY 1977 was that 71 percent of all clients were unemployed at the time of admission, including 53 percent who had not sought employment in the 30 days prior to admission. Over 60 percent of the clients were still unemployed at the time of discharge from treatment.

While there exists no representative follow-up study which can correlate treatment modality with employment, NIDA has some independent studies which suggest that methadone maintenance and outpatient drug-free clients do better than simple detoxification. There is developing a substantial amount of data supporting the concept that intense aftercare or after-treatment supervision dramatically improves treatment outcome when measured by employment.

NIDA is in the process of developing a comprehensive prospective treatment outcome study which will provide valid data about the correlates of treatment including employment related to treatment modality.

Question: What existing impediments do clients face, particularly with regard to Federal, State and local employment and training programs?

Answer: There is stigma associated with drug abuse. Employers and others in the community tend to be misinformed about the behavior and capabilities of drug abusers. A considerable employer investment is required to overcome the factors unfavorable to the employment of drug abuse treatment clients, even assuming that there is a low community unemployment rate and, thus, available jobs.

Certain client characteristics have a negative effect on the probability of employment. These are (1) minority group status; (2) failure to complete high school; (3) no marketable skills; and (4) a record of at least one arrest. When a client with such characteristics also has a history of drug abuse, the unfavorable effects of the other variables are intensified. Persons with these five attributes experience an extremely high level of unemployment. Urban labor markets generally remain closed to them. Even when clients with this mix of social disabilities do find jobs, the work tends to be relatively low-skilled, low-paying and with a large turnover rate. Private employers have been slow to give up their fears concerning the ex-addict and/or addict-in-treatment and are only very slowly beginning to entertain the possibility that employees with drug use histories can function at least as effectively and productively as employees without such histories.

Many clients in treatment are the victims of employment discrimination; they are denied employment because of their addiction histories, or their participation in methadone maintenance or other drug treatment programs. It has been our experience that many persons concerned with trying to place former drug abusers in jobs have ignored employers known to discriminate and have focused efforts solely on employers known to be cooperative. NIDA has taken the position that employment discrimination can and should be fought, and to facilitate vigorous action in support of this belief published last year a document entitled, Employment Discrimination and How to Deal With It. In it we were able to cite landmark court decisions in favor of former drug abusers, specifically, the Legal Action Center successfully challenged discriminatory employment practices by the New York City Transit Authority and the United States Postal Service.

Question: With respect to CETA, Vocational Rehab, and so on? Do you have any data over the past few years of placements of clients in these programs?

Answer: In 1973 the Special Action Office for Drug Abuse Prevention initiated a 2-year demonstration program to explore the feasibility of securing employment for ex-drug abusers through centralized job placement units in four cities (Philadelphia, Chicago, Boston, and Detroit). The special program was based on the following premises: (1) employment is essential to drug abusers' rehabilitation and successful re-entry to society; (2) employers are reluctant to knowingly hire ex-drug abusers; and (3) a centralized placement unit would be the best way to secure employment for ex-addicts.

The study suggested that a concentrated job development and placement effort is helpful for ex-addicts who have stabilized in treatment, and who have moderately good work histories but have never held more than entry-level jobs in the past. It was concluded that even intensive effort - in a period of relatively low unemployment - brings very little if any success in job placement with the clients who have unfavorable work histories. It was estimated that it cost around $1,600 to successfully place a client in a job. In this endeavor, 48 percent of the clients referred were placed in jobs. It also demonstrated that staff with minimal prior experience in vocational counseling and job placement activities appeared capable of developing the techniques for negotiating with local employers for employment opportunities for their clients. Moreover, though it was often initially difficult to enlist the involvement of potential employers, 90 percent of those who did elect to involve themselves later reported a willingness to participate in similar programs in the future. And more than three-fourths of the employers rated the clients as the same as or better than regular employees with regard to overall job performance.

We are encouraged about the potential within the CETA program for rehabilitation, training, job preparation and placement for drug abuse treatment clients. The legislation, however, is extremely complicated and tends to be somewhat intimidating for local program administrators. In an attempt to facilitate utilization of CETA provisions, NIDA's initiatives have brought about a one-day seminar scheduled for later this month in Philadelphia. It is designed to instruct State and local drug abuse program managers from six jurisdictions in HEW Region III in ways to utilize the CETA legislation. If this demonstration is successful, we will replicate it in other Regions during the coming year.

Question: To what degree do private concerns utilize occupational drug abuse programs? What have the trends been over the past few years? Could you supply further detail for the record?

Answer: Interest in occupational drug abuse is relatively recent, and the newness of occupational drug abuse programs limits the extent to which a definitive analysis of these subjects can be made. There are a variety of occupational drug abuse programs in industry, but the total number is probably very small. In 1976 and 1977 NIDA funded two studies to examine the problem of drug abuse in industry. The programs identified in these studies and described in the literature appear to have been established by some of the largest companies in the nation. Smaller companies, which in the aggregate employ the largest number of workers, are less likely to have programs; there is, however, some evidence that small companies have begun to establish programs, especially in the form of consortia or by contracting with outside agencies.

A substance abuse survey was made of 200 companies in the Minneapolis/St. Paul area. The companies sampled had a minimum of 20 and a maximum of 27,000 employees. Fifty-six percent of the companies reported having some employees with drug abuse problems. A more intensive study of 45 firms revealed wide variation in human and financial commitment of the industries with respect to treatment projects. Typically, companies that provide or arrange for drug abuse treatment services are larger, employing 1,000 or more persons, and, in this particular study, were found to be primarily engaged in manufacturing. The majority of the programs had been organized within the preceding three years, usually after experiencing success with occupational alcoholism projects. Many of the drug treatment programs are components of broader employee assistance or troubled employee programs, with drug use viewed as only one of the problems with which an employee may require assistance. Other programs essentially focus on surveillance or idenification of the employee drug abuser, resulting in job termination on discovery. The variations reflect differences in the way the drug abuser is defined and conceived by each company or union. Available community resources differ by locale (rural or urban) and, therefore, locale has an effect on the kinds of action taken.

The extent of drug abuse in the workforce is not known with certainty, but may be greater than employers or line employees perceive, particularly if polydrug abuse is taken into account. Many employers and corporate executives expect the problem to increase as younger employees enter the workforce in increasing numbers.

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LOYMENT STATUS BY MODALITY AT ADM - 1977 DISCHARGES                        05/08/78        PAGE    2
E   NONAME   (CREATION DATE = 05/08/78)

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 EMPST     EMPLOYMENT STATUS                                 BY  MOD      MODALITY AT ADMISSION
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                 MOD
        COUNT   I
        ROW PCT IDETOX,   MAINT,    DRUGFREE OTHER       ROW
        COL PCT I                   ,                    TOTAL
        TOT PCT I      1  I      2  I      3  I      4  I
ST      --------I---------I---------I---------I---------I
              1 I 10099   I  7490   I 21897   I   537   I 40023
MPLADM-EMPLDIS, I  25.2   I  18.7   I  54.7   I   1.3   I  21.6
                I  22.7   I  25.5   I  20.0   I  21.3   I
                I   5.4   I   4.0   I  11.8   I   0.3   I
               -I---------I---------I---------I---------I
              2 I 31249   I 15601   I 67534   I  1610   I115994
EMPADM-UEMPDIS, I  26.9   I  13.4   I  58.2   I   1.4   I  62.5
                I  70.1   I  53.2   I  61.8   I  64.0   I
                I  16.8   I   8.4   I  36.4   I   0.9   I
               -I---------I---------I---------I---------I
              3 I  1364   I  2517   I  6096   I    93   I 10070
MPLADM-UEMPDIS, I  13.5   I  25.0   I  60.5   I   0.9   I   5.4
                I   3.1   I   8.6   I   5.6   I   3.7   I
                I   0.7   I   1.4   I   3.3   I   0.1   I
               -I---------I---------I---------I---------I
              4 I  1844   I  3739   I 13687   I   276   I 19546
EMPADM-EMPLDIS  I   9.4   I  19.1   I  70.0   I   1.4   I  10.5
                I   4.1   I  12.7   I  12.5   I  11.0   I
                I   1.0   I   2.0   I   7.4   I   0.1   I
               -I---------I---------I---------I---------I
         COLUMN    44556     29347    109214      2516    185633
          TOTAL     24.0      15.8      58.8       1.4     100.0

BER OF MISSING OBSERVATIONS = 11274
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NOTE: This table includes all clients discharged during 1977 for whom a matching Admission Report was available. Clients reporting no primary drug or multiple primary drugs <u>are</u> included.

Question: What evaluation activities are conducted by NIDA?

Answer: In any discussion of evaluation, it is necessary that a distinction be made between those activities designed to look at treatment effectiveness, and those which are concerned with program effectiveness from an administrative standpoint. NIDA addressed both these areas. In 1969, the Drug Abuse Reporting Program (DARP) was developed to collect treatment outcome data. The study continued for more than five years, throught the implementation of several pieces of Federal legislation for drug abuse treatment. In 1971, a second contract implemented evaluation research based on during-treatment data in DARP and, more recently, post-treatment follow-up studies on the 1969-72 admissions were initiated. DARP reports were obtained from nearly 44,000 admissions to selected federally-funded treatment centers, representing 25 percent of the total agencies. The focus of the DARP research was on the evaluation of treatment effectiveness across and between treatment modalities: methadone maintenance, therapeutic communities, outpatient drug-free clinics, and detoxification centers. It provided the drug abuse treatment field with some basic parameters by which to measure the effectiveness of their efforts.

After DARP, several smaller but equally important evaluation studies were undertaken by NIDA in an effort to provide a more definitive answer to the question "Does treatment work?" Among these were: "Evaluation of Methadone Treatment in New York City - A Ten Year Overview" which lookrd at the effectiveness of methadone treatment for

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hard core addicts. Another, "Drug Treatment in New York City and Washington, D.C.-Follow-up Studies" assessed and compared the experiences of clients who had contact with/or received treatment from programs of the Addiction Services Agency in New York City and the Narcotics Treatment Administration in Washington, D.C. These studies examined questions of what happens to former clients when they leave treatment and whether differing outcomes are associated with different treatment regimens.

The "Evaluation of the California Civil Addict Program" dealt with the controversial issue of civil committment as a means of providing treatment and rehabilitation to the drug abusing criminal offender, and the results of California's efforts in this area. While this last is not a NIDA program, because of its significant contribution to the field, a NIDA grant was developed to study the work being done and to publish the results.

Although these studies, and others, indicate that treatment does, indeed, work; they were all retrospective evaluations, accomplished after the fact of a drug abuser's treatment experiences. In order to gain more specific knowledge about the treatment process, there is a need to collect data at an earlier point in time; thus the Treatment Outcome Prospective Study (TOPS) was developed as a new evaluation initiative to enlarge upon the knowledge gained in the earlier studies. The TOPS study will track the behavior of drug abusers from initial intake, through and after treatment in order to examine the effectiveness of the various treatment modalities, and the behavioral changes occurring in clients as a result of the treatment experience. TOPS is currently in a Pretest Phase, collecting data in six NIDA-funded programs in two cities. At the end of this six-month period, and following any necessary changes in methodology and/or instruments, TOPS will expand into additional cities across the United States for an 18-month Pilot Phase. The study is designed to look at what kind of client comes to and remains in what type of treatment modality, and what changes occur in the client's behavior. Behavioral outcome criteria such as changes in criminality, employment, drug and alcohol use patterns, etc., will be used to measure the effectiveness of treatment programs in general, as well as the differences in effectiveness between various treatment modalities. This is a joint endeavor with Law Enforcement Assistance Administration's (LEAA's) Treatment Alternative to Street Crime (TASC) Program.

In response to needs expressed by program managers in the field for a method of evaluating their own programs, based on their own data instead of national samples, NIDA developed the Treatment Program Monograph Series. It is designed to provide simple, straightforward presentations relevant to the basic operational aspects of the clinical setting.

The first monograph in the series, A Manual for Drug Abuse Treatment Programs Self-Evaluation, provides the basic tools for each program to establish reasonable treatment goals and assess the quality of its service by measuring the progress of the program in reaching those goals. Such evaluation data can then be used by the program manager to upgrade treatment services and demonstrate accountability for funding. The second monograph, Conducting Follow-up Research on Drug Abuse Treatment Programs, extends evaluation research into the more complex realm of follow-up studies. This volume distills complex theories and techniques into a practical essence for use by local program staff in evaluating interventions which are designed to produce behavioral change. The third volume in the series is the, Statewide Services Contract Program Review Manual. It was developed for managers of drug treatment programs at both the state and local levels. Of the various responsibilities that State agencies carry out in managing statewide drug treatment services, program monitoring and preformance evaluation are among the most important to efficient service delivery. Monitoring functions are used to assess treatment program compliance with contractual requirements and funding policies, as well as to analyze the efficiency of program operations and the program's progress in meeting outcome goals and objectives. This manual is designed to assist states and other interested parties in performing these functions.

Question: How is effectiveness of treatment modalities measured?

Answer: Information is obtained on a number of variables: (1) patient descriptors, which give demographic and background information; (2) baseline measures, the status of the client at the onset of treatment; (3) treatment delivery data, giving information on treatment paradigms and levels of client participation; and (4) outcome measures, behavioral criteria for measuring change. Effectiveness is measured across and between treatment modalities on several of these outcome measures such as: length of time in treatment, drug and alcohol use patterns, employment, other productive actitities, criminality, and life styles.

Question: Is evaluation conducted on a program wide basis, or is each program evaluated individually?

Answer: Both. DARP was designed to evaluate general program-wide effectiveness, and differences in effectiveness between treatment modalities. When fully implemented TOPS will be able to provide information to individual programs. Specific programs are routinely monitored for compliance with Federal regulations in areas such as patient census (utilization rates), staffing patterns, staff/client ratios, linkages with auxiliary services, etc. The Monograph Series is designed to aid programs in improving the quality of services provided.

Question: Who evaluates the programs?

Answer: Again, the distinction between treatment evaluation and program monitoring must be clearly differentiated. Evaluation studies (e.g., DARP, TOPS) are conducted by research scientists; DARP by the Institute of Behavioral Research at Texas Christian University; and TOPS by Research Triangle Institute.

Specially trained program researchers conduct the actual client interviews, and composite data is analyzed by evaluation research experts. Individual programs are monitored for efficiency and compliance with Federal regulations by Program Development Specialists of the Division of Community Assistance (DCA) at NIDA.

Question: What efforts are being made to transfer funding responsibilities from the Federal Government to the private sector, especially third party payments?

Answer: The drug abuse treatment system has evolved almost entirely during the past decade as a parallel health delivery system largely because of the failure of our traditional systems to provide such care. Further, drug abuse treatment has operated largely outside the mainstream of health care financing which takes the form of third party reimbursements, or fee for services. While improvements have recently been seen in the extent of third party payments for treatment, coverage remains rather marginal.

At this time, the level of third party payments, as a national average, constitutes about 9 percent of total program income. This average, of course, is not evenly distributed, as three major states, New York, Pennsylvania and California, collect about 15 percent from third party payments; the remaining states collect only 5 percent of program income through third party sources. Since federally assisted drug programs have to provide local matching monies, a diversified funding model is necessitated. By and large, programs which capture third party revenue use these funds to meet their local matching requirements or to meet the increased costs of operation.

It is important to note that there are a number of barriers to the collection of third party payments for drug abuse treatment. The major constraint lies in basic client eligibility, as eligibility for insurance or third party benefits generally depends on factors such as socio-economic and employment status, age, sex and dependency status. The typical drug abuse client in federally supported treatment programs is an able-bodied, unemployed, unmarried, non-dependent male between the ages of 18 and 30. With these characteristics drug abuse clients are unlikely candidates for third party coverage, a fact borne out by CODAP data which reveals that two-thirds of the clients at admission lack any form of health insurance. Where insurance is held, it is often inadequate to cover the costs of drug abuse treatment.

Other barriers to third party payment for drug abuse treatment result from the nature of drug abuse programs and the types of services provided. Major third party payors are oriented to pay for strictly medical care, i.e., services delivered by a physician or in a hospital. By contrast, drug abuse programs are predominantly outpatient centers, and strictly medical care comprises only a minimal component of the overall treatment/rehabilitation process. As a result, programs may have difficulty gaining the provider status required for reimbursement purposes.

In spite of these limitations, considerable progress has been made in the past two years. NIDA has expended substantial resources for training and technical assistance to improve the capability of drug programs to manage resources and to increase third party payments. An important current initiative is a project with the Blue Cross Association to study the feasibility of instituting broad-based (non-hospital) benefits for drug abuse treatment.

In addition, the Single State Agencies are playing a significant role in developing third party payments through such activities as negotiating interagency agreements with Title XIX (Medicaid) and Title XX (Social Services Funding) State agencies, and in advocating legislation mandating coverage for substance abuse in group health insurance policies in the State.

In summary, it is pertinent to examine the conclusion of a NIDA study on third party payments:

"The picture which has emerged is simply that under current conditions, few treatment programs will be able to rely on third parties as a principal source of funds. Most of the imagined "failure" of treatment programs to exploit third party funding is attributable to factors beyond their control, principally client eligibility. There is a significant degree of untapped third party potential, but not so significant as to permit treatment programs generally to become independent of grant funding. Though the potential is limited at present, both treatment programs and Single State Agencies can do considerably more to improve the actual recovery of funds from third parties to pay for treatment services."

Question: What is the difference in cost effectiveness between outpatient and inpatient care for drug abuse?

Answer: The National Institute on Drug Abuse (NIDA) has been implementing a policy over the last several years designed to reduce the number of NIDA inpatient treatment slots while increasing those slots which are supported on an outpatient basis. This policy reflects the Institute's decision that the overall return on the investment of its inpatient treatment dollars is less than that which is realized on the investment of those dollars in outpatient treatment slots. The number of inpatient slots the Institute supports has dropped from 656 to 422 in the last two years. Conversely, the number of outpatient slots has increased by 3,350 to 79,738.

There are a number of general statements which can be made to distinguish between inpatient and outpatient care. The most significant difference of these is cost. Inpatient care costs are, on the average, sixteen times more than outpatient care. Inpatient care provides a restrictive setting for those whose needs are so great that they can only be impacted by such an environment. Also, there are a small number of clients with concomitant medical and/or severe psychiatric needs who require a restricted environment during the medical detoxification process.

In addition to the higher costs, another limitation of inpatient care is the lack of opportunity it affords for assessing clients' resocialization skills for community reentry. Thus, employment cannot be sought and maintained if the client is confined. Secondary skills, such as vocational and educational training, are generally more appropriately delivered while the client is attempting to function in the community, rather than in the total security of an inpatient environment.

A compromise to inpatient facilities is the therapeutic community. It provides for a gradual reintroduction to the community, the opportunity to gain additional skills, and appropriate supports. Its cost is a fraction of that of inpatient care.

With respect to data collection, could you describe the basic data sources utilized by NIDA? How is this information gathered? How recent?

NIDA collects data for epidemiological information needs and program management needs. The basic information sources operated by NIDA are: The National Drug Abuse Treatment Utilization Survey (NDATUS-annual); the Client Oriented Data Acquisition Process (CODAP-monthly); the National Survey on Drug Abuse (biannual); and the Drug Abuse Warning Network (DAWN-monthly) operated by Drug Enforcement Administration. In order to assist in understanding the utilization of NIDA's information components, each is presented briefly and describes the information collected, why, from whom, how often and what paperwork burden, and when available. (The discussion on DAWN is separate).

A. The National Drug Abuse Treatment Utilization Survey (NDATUS) is a facility-based data collection system which collects information on each unit's capacity, staffing, funding, and funding sources in conjunction with all States. All known drug abuse treatment units report NDATUS data in cooperation with each designated Single State Agency (SSA). The State develops a comprehensive list of drug treatment units in the State which is the basis for conducting the survey. All units regardless of their sources of funds are requested to complete the survey questionnaire and return it to the State which reviews the data and forwards it to NIDA. NIDA processes the information and creates national reports and returns the data to the States with State reports.

   NDATUS data are collected by means of questionnaire which is mailed to all known treatment units. NDATUS is an annual data collection effort. Since the effort has been ongoing for several years, a large majority of reporting units are familiar with basic NDATUS requirements. To assist units and minimize paperwork some information on the form is computer printed and only changes are required. The information is reported from basic treatment and fiscal reports maintained at or for the treatment unit. Included this year are FDA Methadone Monitoring reporting requirements, required by law. Therefore, all records are maintained at the unit specifically for this purpose and additional paperwork is not generated. The average response time required for NDATUS per unit is 30 minutes, thus the entire paperwork burden on the unit is 30 minutes per year.

B. The Client Oriented Data Acquisition Process (CODAP) is designed as a single, national, recurring reporting requirement used by all Federal agencies except the Department of Defense. Information is collected for client-related drug abuse from all drug abuse treatment centers receiving Federal funding. Thus, CODAP includes the Department of Health, Education, and Welfare (DHEW), Bureau of Prisons (BOP), Veteran's Administration (VA), and Law Enforcement Assistance Administration (LEAA). The States collect these data for NIDA, thus insuring comparable information available to each State. CODAP is authorized under the provisions of Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972.

CODAP collects admission and discharge information on clients resulting in the processing of over 37,500 forms per month. These data serve as the Institute's primary source of information regarding patterns of drug abuse treatment practices and characteristics of clients in federally-supported treatment facilities. Currently, CODAP collects information from 1,600 drug abuse treatment centers which take approximately 10 minutes per form to complete. This is a reduction of 30 percent from 1976. In 1979 we hope to realize an additional reduction of 10 to 20 percent. In 1977, approximately 192,000 clients were admitted to treatment reported to CODAP.

DSPI/NIDA gathers, organizes and analyzes CODAP data and publishes the results on a quarterly and annual basis through the NIDA Statistical Series. The quarterly reports are published within approximately six months of the completion of the data collection and the Annual Report within one year. Special analyses are prepared for the VA, BOP, SSA's, programs and clinics, Congressional requests and queries from the research and academic communities. Examples of research conducted on CODAP data include epidemiological studies on incident and prevalence of drug abuse, new trends in abuse such as phencyclidine (PCP) and various studies on female and minority drug abusers.

C. The National Survey on Drug Abuse is a biennial sample survey of persons age 12 and older living in households in the contiguous United States. The information in this survey is self-reported by individuals who fill out questionnaries during an interview session. Because it is a household survey, there is no involvement with individual treatment facilities. The survey is conducted every other year, the most recent survey being in 1977. The data are disseminated within the same calendar year.

D. One of the basic data sources utilized by NIDA is the Drug Abuse Warning Network (DAWN). This information is gathered weekly from selected hospital emergency rooms and medical examiners throughout the United States. The work is done by the contractor, IMS America, Ltd., for this project which is carried out cooperatively between the National Institute on Drug Abuse and the Drug Enforcement Administration. Each agency contributes about $900,000 per year and the contract is managed by the DEA.

The paper work burden on individual facilities is a function of the frequency of which drug abuse cases are seen. Typically from one-half to somewhat over one percent of emergency room visits are, in fact, drug abuse cases. The reporting form is short, consists of only one page and is filled from the medical records. Facilities are paid to carry out this work.

Results are disseminated in a quarterly publication and an annual publication both of which cover the entire system. Other results are disseminated as the need arises to answer questions or to obtain information for research and assessment reports.

At the very least there is a two month lag between the time that an event has occurred and the time the data are published. However, under-reporting in the immediate reporting month suggests that a more appropriate time lag would be three to five months. DAWN is capable of monitoring trends on any drug abuse substance entered into its system. There are 3,000 such substances although only about 10 percent of them appear with enough frequency to warrant a trend analysis. For example, only about 300 drugs or drug categories reached a frequency of 25 cases within a two and a half year period. This type of trend analysis is carried out routinely at NIDA and is reviewed for the Executive Staff every other month.

Outside consultants typically are not employed with respect to the DAWN project although a reliability study is in the initial stages. This study would be carried out by an outside contractor at a cost of approximately $250,000.

"With respect to treatment for abuse of licit drugs, what evaluation have you done of effectiveness? Rate of successful recovery? Short-term and long-term?"

Questions dealing with treatment for abuse of licit drugs are in themselves difficult, because while drugs may be licitly manufactured, they may be illicitly obtained. The National Institute on Drug Abuse as a study currently underway to assess the magnitude of illicit use of prescription drugs. The complexity of the problem may be seen in: (a) the diversion of legitimately obtained drugs to illicit use; and (b) the abuse of licit drugs in conjunction with illicit drugs (as in the case of persons mixing amphetamines and heroin). Because NIDA's primary concern is with the treatment of the drug dependency rather than the channels through which drugs were obtained, no distinction is made in our treatment statistics as to the source of the drug. Our CODAP data base which reports admissions and discharges of clients to drug treatment programs classifies clients on the basis of primary drug of abuse--presumably the drug for which the client enters treatment. The major categories of "licit" drugs reflected in CODAP statistics are amphetamines and barbiturates, which during the second quarter of 1977 accounted for 2,638 discharges or 10 percent of the total discharges. These CODAP figures show that about 25 percent of those clients discharged from treatment for these two groups of drugs complete treatment, while an additional 18 percent are transferred to other programs to continue treatment. It might be pointed out that failure to complete a course of treatment does not necessarily mean that the individual returns to drugs. Several of our studies have shown that many persons leaving treatment early abstain from using drugs without additional intervention.

In terms of long-term recovery, our research in this area is not yet complete; however, some figures are available with regard to recovery from nonopioid use, a category which includes such illicit drugs as cocaine, but which is predominantely amphetamines and barbiturates. In the followup research conducted by the Institute of Behaviorial Research, comparisons were made for nonopioid use before entry into treatment and after completion of treatment. The preliminary results we have obtained suggest that there is a general tendency for nonopioid use after entering treatment to diminish over time. In a sample of 1,077 clients admitted to treatment between 1969 and 1971, Sells found that 34 percent reported daily or weekly nonopioid use (did not include marihuana), and the same percentage reporting nonopioid use at some time since treatment termination, although only nine percent reported daily or weekly nonopioid use at the time of the followup interview. A later report, based upon 2,011 clients admitted to treatment during 1969-1972, and who were followed up after completing treatment, found that during the first year after treatment the methadone maintenance, therapeutic community, and outpatient drug-free clients all showed statistically significant reductions in nonopioid use, while those individuals receiving no treatment other than detoxification experienced reductions in nonopioid use which were not statistically significant. On the basis of these data, which are presented in the attached report "Evaluation of Drug Abuse Treatments Based on the First Year After DARP" - Table 4, it is possible to state with confidence that the major treatment modalities are having a significant impact in the area of treating persons with drug dependency involving licit drugs.

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Number and percent of CODAP discharges completing treatment by modality at admission and primary drug at admission

Drug Free	Number	Percent	Total N
Opiate	5,017	17.0	29,516
Non-Opiate	11,817	29.5	40,023
Maintenance			
Opiate	3,082	14.1	21,827
Non-Opiate	—	—	—
Detoxification			
Opiate	5,342	21.4	24,972
Non-Opiate	1,038	28.3	3,670
Other			
Opiate	100	16.1	621
Non-Opiate	191	19.2	993

Source: CODAP Discharges, January - December 1977

Note: This table is based on those clients discharged during the year for whom a matching Admission Report was available. Clients for whom no primary drug was reported and those for whom multiple primary drugs were reported are excluded.

All clients, not only NIDA-funded clients, are included in the figures; however, NIDA clients make up the majority of CODAP admissions.

Although CODAP does collect data on the number of times a client was arrested during the 24 months prior to admission, it does not collect data on the type of offenses related to the arrest.

To what degree are NIDA resources devoted to treatment of abuse of so-called hard drugs vs. licit drugs, including over-the-counter drugs?

	Opiates	Non-Opiates	Total N
Number of Admissions	83,271	55,305	138,576
Percent of Total Admissions	60.1	29.9	100.0

Source: CODAP, Jan-Dec 1977 Admissions

Note: Clients for whom no primary drug was reported and those for whom multiple primary drugs were reported are excluded from this table. Also excluded are transfer admissions from CODAP clients.

Might these proportions be reconsidered in light of the ratio of populations involved?

The "Comprehensive Drug Abuse Prevention and Control Act of 1970" (P.L. 91-513) extended the authority of the National Institute on Drug Abuse to support services for narcotic addicts "and other persons with drug abuse and drug dependence problems." The responsibility for determining which type of drug abuser will receive services supported by our funding lies with the service provider. We only require that services are provided to the client(s) with the greatest clinical need.

What is the rate of success of such treatment? For heroin? For each modality of treatment? Short term vs. long term?

	Number Completing Treatment	Percent Completing Treatment	Total N
All Clients	26,660	21.9	121,984
Heroin Clients	12,504	17.4	71,921

Source: CODAP, Jan-Dec 1977 Discharges

Note: This table is based on those clients discharged during the year for whom matching Admission Reports were available. Clients for whom no primary drug was reported and those for whom multiple primary drugs were reported are excluded.

What proportion of NIDA funded clients in heroin treatment programs have prior criminal records? Over the past 3 years what types of offenses generally?

37,878 (52.5 percent) of all clients admitted in 1977 with a primary drug problem of heroin had been arrested one or more times in the 24 months prior to admission.

Source: CODAP, Jan-Dec 1977 Admissions

Note: This table is restricted to clients for whom revised 1977 CODAP admission forms were submitted. Clients for whom no primary drug was reported and those for whom multiple primary drugs were reported are excluded from this table. Also excluded are transfer admissions from CODAP clinics.

PREVENTION

Question: In the President's proposed 1979 Budget, what level of funding is proposed for NIDA drug abuse prevention activities? What proportion of total NIDA funding does this represent?

Could you supply this same information for the past three years?

Why the declining proportion?

To what reasons do you attribute this decline?

How do these proportions compare with the proportion of funds States allocate from their formula grants for prevention?

What was NIDA's professional judgment budget for these functions?

NIDA Prevention
(Dollars in Thousands)

	1976	1977	1978	1979
Total NIDA	$232,628	$259,747	$262,099	$275,271
Prevention Activities	$3,658	$4,706	$6,493	$5,090
Proportion	1.6%	1.8%	2.5%	1.8%

Community programs funds are limited by law to $200,000,000. Treatment costs, however, continue to be forced upward by inflationary pressures. Therefore, in order to maintain at a constant level, both the quantity and quality of treatment services, NIDA's first priority, the funds available for other activities such as prevention and demonstrations decrease.

According to the latest estimate from data provided by the states, the states currently allocate approximately 30% of their formula grant funds for prevention activities.

NIDA's original request for prevention activities in FY 1979 was $8,385,000.

"Could You Elaborate on NIDA's So-called Prevention Cost Accountability Model and Its Public Policy Implications and Could You Provide Further Details on This for the Hearing Record?"

In 1977, an Institute-wide Task Force study of prevention was completed. The need for cost/benefit analysis of drug abuse prevention programs was recognized and it was determined that such studies were feasible. It was further noted that an empirical data base upon which to proceed was largely missing. Also, the Task Force concluded that cost/benefit studies probably could not hope to deal satisfactorily at present with the non-quantifiable intangible benefits of prevention. Therefore, cost/benefit analysis would inevitably constitute only a part of the overall evaluation of drug abuse prevention efforts.

Working from certain assumed values for some important variables in prevention programs, the Institute's Office of Program Development and Analysis undertook a limited study to examine whether cost-effectiveness in primary drug abuse prevention is possible and to explore some viable approaches (see attached technical paper - "Cost Accountability in Drug Abuse Prevention").

Conclusions reached by that study include that:

1. The empirical data base for prevention programs is inadequate.
2. There is an urgent need to define baseline rates of dysfunctional behavior.
3. There is a similar need to gain fuller knowledge about the long-range career costs of dysfunctional use of drugs.
4. Effectiveness levels must be developed on a model-specific basis as costs do not compare across model types.
5. Long-range cost-effectiveness in drug abuse prevention programs is achievable.
6. Cost accountability is only one - however important - factor to be considered in assessing fully the value of drug abuse prevention programs.

As a preliminary step to field validation and application of such models (preliminary reports from that effort are attached) in July of 1977, a contract was let by the Prevention Branch to Pennsylvania State

University to identify four (4) cost/benefit cost-effectiveness models to apply to accepted prevention modalities (Information, Education, Alternatives and Intervention). The objectives are to develop conceptual cost/benefit models, determine their feasibility, and to recommend to the Institute data collection methodology for implementation.

A method for determination of average social costs has been developed (see Executive Summary of Contract Report). This effort is scheduled for completion by June 30, 1978 after which, depending upon the availability of funds, the Prevention Branch plans to field test, validate and disseminate to SSAs, local prevention programmers and decision makers at all levels the fruits of this research.

The attached release from the Orange County Department of Education represents the type of program that the Institute plans to examine with its models. If the average costs of a high risk participant in a prevention program is assumed to be $140 per year as Table 2 of the Executive Summary Cost Benefit Contract reveals, as compared to the overall career costs of a dysfunctional drug abuser at $41,000 (see Orange County Department of Education attachment) the wisdom of investing in effective prevention efforts is overwhelming.

Once cost benefit models have been fully validated through field tests of ongoing or newly developing programs, they will be of enormous benefit to prevention programmers at all levels of Government and should assist the Institute and the Congress in budgetary decision-making.

While it may be impossible to determine how many individuals would have been drug abusers but for a particular prevention strategy, do there exist any longitudinal studies attempting to measure this? Through control groups and so on?

At present, there are four NIDA-sponsored studies exploring this issue. The first is the evaluation of the Charlotte Drug Abuse Education Center (NIDA grant #DA 01562-02); the second is the evaluation of the Cities in the Schools program in Atlanta, Georgia, by Dr. Fred Crawford of Emory University (NIDA grant #DA 01708-01); the third is a three-year longitudinal evaluation of the State of Nevada's Drug Abuse Prevention Program (NIDA grant #DA 02005-01); and the fourth is an evaluation experiment that tests the effectiveness of five drug abuse prevention strategies (self-management instruction, peer and cross-age tutoring, values clarification, neighborhood service alternative, and creative drug education) in the Napa Valley Schools in California. This three-year study is awaiting final approval from NIDA and should commence during the summer of 1978.

Each of these studies is longitudinal in nature. The evaluation of the Charlotte Drug Education Center is based upon drug use incidence and prevalence data collected over an eight-year period (1969, 1972, 1974, and 1977); the grant commenced in January of 1977 and is beginning to report preliminary findings concerning effectiveness of its "Ombudsman" prevention strategy for students in the fifth through the twelfth grades. Two recent studies completed under this grant are appended. The first is an analysis of the four school-wide drug use surveys administered in 1969-1977. The second report discusses the effectiveness of the Ombudsman program to interrupt and prevent drug use behaviors among youth participating in the Ombudsman program. A brief summary of the findings of that study are provided below.

The evaluation of the Cities in the Schools program commenced in August of 1977 and preliminary findings are not yet available.

The evaluation of the State of Nevada's Prevention Program is scheduled to begin in April, 1978.

A brief description of each of these longitudinal prevention evaluations follow.

1. The Ombudsman Program (Charlotte, N.C., 1977) has been primarily designed for the students of the elementary and high school levels. In general, students are involved in a semester-long Ombudsman class where they learn about themselves, develop skills in communications, decision-making, and establish helping relationships with others. Students involved in these classes are encouraged to become "Ombudsmen" themselves in their schools or in their communities. In addition, the Ombudsman instructors are encouraged to work closely with the principals, guidance counselors, homeroom teachers, or other health teachers in the schools where the program is implemented. An evaluation of the project (Kim, 1978) reports that program participants (in relation to comparison groups) evidenced positive changes in six (of ten) drug-use related psycho-social areas: self-acceptance, sense of well-being, cognition of self-understanding, coping ability, parent/child relationships, and positive social attitudes. In addition, preliminary findings from a school-wide epidemiologic survey of drug use indicates that students (fifth graders in particular) participating in this prevention program tended to stop their use of a wide variety of licit and illicit drugs to include cigarette smoking, phencyclidine and marihuana. And that in general (across all grades and all drugs) that the Ombudsman Program is most effective in regard to "hard drugs" ($p < .001$), but not as effective with the social use of the "soft drugs" such as cigarettes, alcoholic substances and marihuana (This is particular true in the 10-12 grades); and that the program has greater impact in stopping drug use among students in the lower rather than the higher grades ($p < .05$).

2. Under a NIDA grant, Dr. Pred Crawford of Emory University will measure the effectiveness of Atlanta's Project Propinquity. Based at Smith High School and at several street academies, the Atlanta program brings together representatives of all the agencies designed to help young people such as the schools, the juvenile court system, the health department, welfare agencies and the police. The Atlanta programs operate under an umbrella agency called Exodus.

   Some 500 young people with problems are grouped together at school in "family units" of ten centered around a counselor. The counselor is available around the clock when the students need help.

The Propinquity Program takes students who are not succeeding and gives them the assurance and support they need.

The evaluation of the project seeks to determine if this project is cost-effective. Measures include data from students (demographic, attitudinal, drug-use levels), counselors, and teachers. Cost data relevant to the program's operation is being provided by the school system. In general, the study will show the actual dollar cost of all the social services provided to the student and will record what happens to that student as a result of the program.

Note: Project Propinquity is currently being expanded as a national school-based program. In a consortium effort, DHEW, DOL and DOC are supporting the extension of the project to three other cities. Identified as the "Cities in the Schools" program, the national effort is being evaluated under a contract sponsored by the National Institute of Education.

3. Under a NIDA grant, the University of Nevada will conduct a longitudinal evaluation (three-year) of Nevada's Drug Abuse Prevention Program that has been in existence for six years in the Nevada schools. Nevada offers a drug abuse prevention curricula (grades 5-9) that focuses upon decision-making related to substance abuse, coping with peer pressure and the influences of advertising, and promotion of responsibility to self and others. For the evaluation, a sample of 15,000 students who are in grades 5, 7 and 9 will be selected for participation in the three-year evaluation. This sample population will consist of an experimental group and a control group. The experimental group will consist of those students who will be participating in the Nevada Drug Abuse Prevention Program during 1977. The control group will consist of students who have not participated in the Drug Abuse Prevention Program during the same time period.

   Both groups will be tested at seven different time intervals during the three-year project period and compared on measures of drug use, intention to use drugs, self-concept, and decision-making skills. Comparisons will also be made utilizing socio-economic status, ethnic background and sex.

4. An experimental evaluation of five prevention strategies will soon (summer, 1978) commence in California Napa Valley School System. This three-year project will attempt to implement and evaluate five school-based primary prevention strategies (self-management, peer

and cross-age tutoring, values clarification, service alternatives, and creative drug education). The intent of this effort is to identify the most promising and replicable prevention strategies now in general use and to provide a solid empirical grounding to current drug abuse prevention theory. The prevention strategies will be assessed in both short-term and long-term studies. The short-term studies will be conducted during the first year of the project and will consist of all fourth, fifth, and sixth graders in eight elementary schools; and approximately 1500 junior high school students. Participants in the long-term studies (referred to in the proposal as "cohorts studies") will consist only of third and seventh graders. The third graders (referred to as Cohort I) will receive a three-year sequence of interventions beginning in the first year of the project. The seventh graders (Cohort II) will receive a two-year sequence of interventions beginning in the second year of the project. All the prevention strategies will be implemented and tested within the Napa Valley Unified School.

The evaluation plan will utilize experimental and control groups for each of the short-term (one-year) and cohort (three-year) studies. Two of the short-term studies (self-management and cross-age tutoring) will consist of all fourth through sixth grade students in eight randomly selected elementary schools. In the three short-term studies at the junior high level, (values clarification, creative drug education, and service alternatives) individual students will be randomly assigned to either experimental or control conditions.

The long-term studies will involve two cohort groups. Cohort I will consist of approximately 300 randomly selected third grade students, and Cohort II will consist of approximately 300 seventh graders. Each group will have matched controls.

- Both control and experimental groups will be tested using pre and post-test designs to determine if exposure to one or more of the prevention strategies will affect changes in students' behavior that are associated with drug-specific outcomes and with other cognitive, affective, and behavioral outcomes. Some of the variables to be measured include attitudes toward school and peers, academic self-esteem, academic achievement, discipline problems, decision-making and problem-solving skills, drug knowledge, and drug use behavior. Specific instruments to be used have not yet been selected, but the following ones are under consideration: 1) Classroom Environment Scale (Moos and Humphrey); 2) Piers-Harris Children Self-Concept Scale; 3) PV-Ind Scale (Jessor); 4) California Study Methods Survey-Planning and System Subscale; 5) Classroom Environment Scale--Involvement Subscale (Moos and

Trickell); 6) Locus of Responsibility Scale (Bills); and 7) PV-ACR and E-ACR scales (Jessor).

Analysis of data will include multivariate analysis of variance and covariance, multiple regression, and path analysis. These analyses will be supplemented by various types of sociometric, content and observational analyses, to describe changes in peer group, classroom, and school functioning.

S[redacted] 2916 requires that not less than $24 million be devoted to prevention activities. Congressman Rogers' Bill does the same. Could NIDA put these resources to good use in the prevention area?

In addition to prevention activities, the $24 million figure includes services demonstration and related activities such as technical assistance to treatment programs. Approximately $15 million of the $24 million could be allocated to prevention. NIDA's Forward Plan (fiscal year 1979-1982) fully describes a comprehensive national prevention program that addresses changes in Lifestyles, delivery of Services, and enhancement of Environmental factors related to prevention. The expenditure levels for these programs are:

FY 1980 - $15.364 million; FY 1981 - $15.714 million; and FY 1982 - $15.599 million.

Specific program initiatives include:

Lifestyle

1. Validation of Smoking Prevention Models for Youth - The focus of the initiative is the evaluation and the testing of innovative smoking prevention strategies in five communities.

2. Epidemiologic Survey of Life Stress Coping Behaviors and Drug-Use Behaviors - A research effort to identify the relationships between the life-stress events and individual coping strategies to these events with initial drug use behavior of youth.

3. Validation and evaluation of "Coping with Stress" Drug Abuse Prevention models. - The project will develop and validate three "Coping with life-stress" models and evaluate the effectiveness of these models to moderate drug use behaviors.

4. Ethnographic Study of Family/Parenting Practices and Drug-Use Behaviors - This study will explore the development of family parenting practices, communication patterns, and family coping strategies in five groups of ethnic families and assess the relationship between these factors and drug use behavior.

5. Pilot Test of Prevention-Oriented "Risk Management" Models in Five States - It is the intention of this program to develop prevention models that assist youth and their families to become aware of the risk levels associated with drug use and to develop better drug-related decision making skills.

Services

1. Acquisition of new prevention knowledge through evaluative research of prevention strategies (Prevention Grants Programs) - This project validates through evaluative research, innovative education, information, alternatives, and intervention drug abuse prevention programs.

2. Replication studies of innovative prevention strategies - This project tests the use of valid drug abuse prevention strategies with different target audiences and different communities.

3. Catalysts for community-based prevention programs (youth-serving groups) - This project is designed to build a natural prevention consortium of youth-serving agencies to participate in community-based drug abuse prevention programming

4. Private sector alliance building - The purpose of this initiative is to assist the private sector to "focus" their attention on drug abuse as a national problem and to promote their active involvement in drug abuse prevention at the local, State, and national level.

Environment

1. Capacity building for Single State Agencies for Drug Abuse.

   o State Prevention Coordinator's Program - This program establishes a NIDA funded Prevention Coordinator in participating States.

   o Prevention Professional Standards Study - This study will analyze the job functions and responsibilities of "drug abuse preventors" and establish educational/training and performance requirements for the profession.

   o Prevention Continuing Education Programs - This is a NIDA sponsored,State administered educational support program to prepare professionals to work as drug abuse preventors.

2. National prevention evaluation resource network for State and local drug abuse prevention programs - This national program provides States and local prevention programs with the technical assistance and resource support needed to evaluate their prevention programs.

3. Technology transfer of "proven" drug abuse prevention materials, products, and processes.

   - Project Pyramid - This project provides information and consultant assistance to State and local drug abuse prevention programs.

   - Center for Multi-Cultural Awareness - The center provides on-site technical assistance to minority programs.

4. Public education

   - National Drug Abuse Prevention Campaigns and Evaluations - This project is intended to increase public awareness and involvement in drug abuse prevention.

   - Sleeping Pill Campaign - A public and physician education program to reduce the annual number of prescriptions for sleeping pills.

   - Public Attitude Assessment - A project to assess the factors related to changing public attitudes on drug use behavior; a study of appropriate media and messages.

   - Prevention Materials Development and Dissemination - Development and distribution of prevention-related materials, videotapes, posters, monographs, etc.

Each of these prevention program initiatives are fully described in the attached copy of NIDA's Drug Abuse Prevention Plan.

March 31, 1978

NIDA Drug Abuse Prevention Plan

A. BACKGROUND AND HISTORY

At the time the National Institute on Drug Abuse (NIDA) was established, April 1974, there was vagueness about definitions and practice concerning prevention. The first major step to dispell some of this vagueness was to assemble a task force under the direction of the Prevention Branch. A common definition and understanding by experts from Federal, State and local programs was set forth and priorities and directions for Federal, State and local programs were established. At the request of State and local communities, a number of initial efforts were service oriented. It was soon recognized, however, that under a limited budget, the major focus should be concerned with acquiring new knowledge and developing and supporting resources to strengthen State and local prevention activities, rather than supporting operating services. A variety of programs and projects, therefore, were initiated in FY 75 and 76 that were consistent with this objective.

More recently, the Cabinet Committee on Drug Abuse Prevention Treatment and Rehabilitation report of the Subcommittee on Prevention (see attached brochure) provided further support for these objectives by stating that the Federal Prevention effort should:

1. Provide leadership as a national catalyst--and take an aggressive role in human resource development and knowledge development.

2. Collaborate in the targeting of resources and deliver the technical assistance and planning required for effective resource utilization.

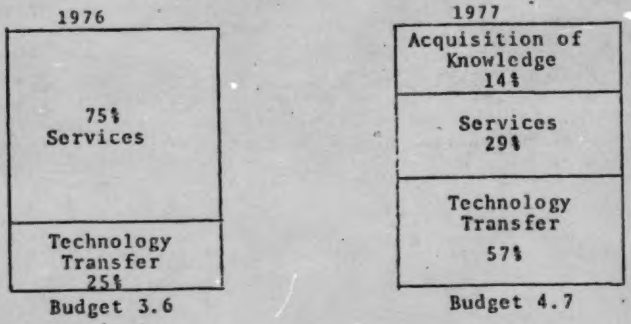
3. Provide leadership in collaboration with States for building capacity of the local level as the primary deliveries of prevention services.

The National Institute on Drug Abuse (NIDA), in keeping with these recommendations, has initiated a number of short and long term coordinated efforts to further systematize prevention efforts and assist State Drug Agencies to reprogram their prevention initiative.

'NIDA's basic program strategy, acquisition of knowledge and technology transfer has significance for health promotion that is not immediately recognized. For instance, our activities over the past few years include:

- development of a State oriented national evaluation network for prevention related efforts.
- establishment of a sophisticated planning process with the States for prevention of related efforts.
- establishment of a technical assistance delivery system for the United States in prevention planning and implementation. It is highly cost effective, efficient and credible.
- establishment of a national system for prevention replication to effectively coordinate the underutilized potential of community resources and determined its feasibility on a national basis. Plans now are under development with the Prudential Insurance Company for further implementation of this national program.
- development of major components for a national system that will provide better coordination of prevention audio-visual print and other support materials.
- development of grant guidelines reflecting the need for evaluative research as the primary purpose of the grants program.
- establishment of coordinated system to meet the prevention needs of major ethnic minorities.

PAST PREVENTION BRANCH
FUNDING TRENDS BY STRATEGY



B. PROPOSED DRUG ABUSE PREVENTION PROGRAM IN FY 78-82

NIDA DRUG ABUSE PREVENTION GOALS: 1978 - 1982

1. Develop replicated Prevention Service Programs which reverse the trend of increased use of gateway drugs (marijuana, tobacco) among youth (focusing upon those 8 to 20 years of age) as measured by estimates of drug use prevalence.

2. Develop replicated Prevention Service Programs which reverse the trend of increased use of cocaine, inhalants, and phencyclidine among youth (focusing upon those 8 to 20 years of age) as measured by estimates of drug use prevalence.

3. Continue to identify individual emerging drugs of abuse and to alert the medical community and the general public concerning the risk factors associated with drug use.

4. Develop replicated Prevention Service Programs which modify the attitudes/beliefs of youth concerning the physical and psychological risk levels associated with drug use behavior as measured by estimates of drug use prevalence/attitudes.

5. Promote community-based health promotion and drug abuse prevention programs by strengthening the prevention capacity of State and local drug abuse prevention programs.

PREVENTION PROGRAM RATIONALE

Based upon recent epidemiologic survey data measuring the prevalence of drug use (Johnston, Backman, O'Malley, 1977; Cisin 1977) and after a careful analysis of Prevention Planning documentation (NIDA, PHS Task Force on Prevention, White House Sub-Committee on Prevention), NIDA's Drug Abuse Prevention Goals (FY 80 -85) have been developed.

Recent epidemiologic data provides NIDA with an indicator of the current drug abuse problem in the country. These data show the drug abuse problem of today that should be addressed by national drug abuse prevention programming for tomorrow.

For example the annual drug use surveys of high school seniors (Johnston, 1977) shows that there has been:

1. An appreciable rise in marijuana use since 1975.

1975	1976	1977
40.0%	44.5%	47.6%

2. An increase in alcohol use since 1975.

1975	1976	1977
84.8%	85.7%	87.0%

3. An increase of cigarette use (lifetime prevalence) since 1975.

1975	1976	1977
73.6%	75.4%	75.7%

4. An increase in cocaine use since 1975.

1975	1976	1977
5.6%	6.0%	7.2%

5. An increase in inhalant use.

1975	1976	1977
N/A	3.0%	3.7%

6. Stabilization of stimulants, sedatives (slight decrease), tranquilizers.

7. Negative shift in youth attitudes toward drug use. Youth are slowly developing attitudes that tend to ignore the risk levels (physical, emotional) associated with drug-taking behavior. According to the Johnston survey, the decline in the percentage of youth failing to associate drug use as a "high risk" behavior varies from 1 to 7 percent (1975 to 1977) across all drugs (licit and illicit) except cigarette smoking. With cigarette smoking, the survey reports more youth since 1975 indicating cigarette smoking behavior as placing an individual at "great risk" of physical or emotional harm.

In general the recreational and addictive use of drugs to include (illicit and licit drugs) pose a serious health threat to the lives of millions of American youth. NIDA's Drug Abuse Prevention Goals are in response to this national problem.

A second source of guidance for the forward planning process involves an analysis of recent drug abuse prevention planning documents to include the Recommendations of the White House Cabinet Committee on Drug Abuse Prevention, Treatment, and Rehabilitation--Report of the Subcommittee on Prevention; the PHS Prevention Task Force Reports (Lifestyles, Services, and Environments) and NIDA internal planning documents.

These reports of blue ribbon panels and Federal task-forces indicate the current levels and types of drug abuse prevention programming available at the Federal level and the gaps in prevention research and prevention program activities that need to be bridged in order for effective drug abuse prevention to occur.

The documents demonstrate that prevention programs to promote positive well-being are required in three program areas: Lifestyles, Services and the Environment. Target areas where there is insufficient Federal programming involves: smoking behavior, risk management, stress reduction, family nurturing, capacity building, minority needs, and health education.

These reviews of Federal needs, document that more prevention research, prevention evaluation, and program development activities should be initiated by the Federal government in cooperation with State and local governments and in alliance with the private sector. NIDA's leadership role in the prevention of drug abuse is reflected in the statement of NIDA's Prevention Program Objectives that follow.

DRUG ABUSE PREVENTION OBJECTIVES

Lifestyles

1. Develop replicated service initiatives focused on preventing youth (particularly teenage girls) from initiating and maintaining cigarette smoking behavior through the implementation of effective smoking prevention interventions. (Goal 1)

2. Assess the relationship between stress and drug use behavior by youth and validate effective drug abuse prevention strategies to assist individuals to better manage life-stress events. (Goals 1, 2)

3. Strengthen parenting practices, family communication skills, and family coping abilities through the promotion of prevention research and prevention interventions. (Goals 1, 2, 4)

4. Promote among youth the acquisition of positive "Risk Management" skills to include sensitization to personal risk levels associated with drug use, development of appropriate drug-related decision-making skills and the initiation of self-protective health practices. (Goals 1, 2, 4)

Services Through Cost Containment Strategies

1. Validate effective drug abuse prevention strategies (information, education, alternatives, and intervention) that meet the unique needs of special target groups (e.g., youth, minority populations, families, and the elderly). (Goals 1 - 5)

3. Promote greater participation in drug abuse prevention of national and local youth-serving agencies to act as catalysts for community-based drug prevention programs. (Goal 5)

4. Encourage the private sector to take a more active role in prevention through sponsorship of employee drug abuse prevention programs and by corporate participation in community-based drug abuse prevention programs at the national and local level. (Goal 5)

Environment (System Enhancement)

1. Promote the development of effective drug abuse prevention programs at the State level by increasing the capacity of single State agencies for drug abuse to plan, implement, and monitor drug abuse prevention programs. (Goal 5)

2. Coordinate the systematic evaluation of drug abuse prevention programs on the national, State, and local level. (Goals 1, 2, 3, 4)

3. Transfer proven drug abuse prevention technologies (technical assistance, prevention materials, prevention techniques, and process to States, local communities and individual drug abuse prevention programs attempting to establish community-based drug abuse prevention programs. (Goals 1-5)

4. Develop and validate public education initiatives that alert the general public, families, and professionals to the roles each can play in preventing drug abuse. (Goals 1 - 5)

CURRENT INITIATIVES

NIDA Prevention contract initiatives for fiscal year 1977, 1978, and 1979 (planned) are presented below. In addition to contracts, the National Institute on Drug Abuse funds a Prevention Grants Program. Funding levels for this grant's program follow: 1977 - $1.5 million; 1978 - $2.1 million (estimated); and 1979 - $3.0 million.

Fiscal Year 1977

PYRAMID: A resource sharing technical assistance network with State and local level groups. Eastern and Western Offices.

Cost:	$576,513	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Capacity Building

Channel I: This project in cooperation with Prudential Insurance Company is designed to stimulate new prevention efforts and assist existing efforts at the local level involving 12 pilot cities. Based upon successful Gloucester Grant experiment.

Cost:	$ 97,634	Target Category	Health Promotion
Target Area:	Services	Intervention:	Service Demonstration

SSA/Plannings: The ultimate goal is to develop a Single State Agency (SSA) component with sophisticated understanding of prevention concepts, strategies and processes, and skills in implementing State prevention programming.

Cost:	$176,946	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Capacity Building

DAP Campaign: This effort is designed to initiate and coordinate a series of programs and activities across the nation highlighted by Drug Abuse Prevention Week (January 16 - 22).

Cost: $486,045 Target Category: Health Promotion
Target Area: Environment Intervention: Health Education

DAP Campaign Evaluation: This effort evaluates the effects of the DAP Campaign on the target audience.

Cost: $165,478 Target Category: Health Promotion
Target Area: Environment Intervention: Evaluation

Elderly: An effort for developing materials to encourage senior citizens toward wise consumerism of drugs.

Cost: $186,079 Target Category: Health Promotion
Target Area: Lifestyle Intervention: Health Education

Retargeting: An effort to encourage community organizations to allocate more funds for prevention. The purpose is to develop a demonstration model to encourage youth-serving organizations to do more about prevention.

Cost: $ 95,998 Target Category: Health Promotion
Target Area: Environment Intervention: Capacity Building

CMA (Center for Multicultural Awareness): This project represents a unique effort by a Federal agency to meet the prevention needs of various ethnic minorities. It provides for on-site technical assistance to minority programs (State level) and materials development.

Cost: $501,680 Target Category: Health Promotion
Target Area: Environment Intervention: Capacity Building

Satellite Conference: A nationwide experimental event beamed by satellite to provide youth a forum to discuss their concerns and thoughts on drugs.

Cost: $ 50,816 Target Category: Health Promotion
Target Area: Services Intervention: Health Education

- Video Model: An effort to encapsulate successful programs (with sound evaluation components) on video tape. Focus is on school, community, and youth-initiated activities.

Cost:	$169,725	Target Category:	Health Promotion
Target Area:	Services	Intervention:	Health Education

Cost-Benefit Model: An attempt to develop a hypothetical model which outlines a cost savings analysis for prevention.

Cost:	$ 41,130	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Evaluation

Fiscal Year 1978

PYRAMID (Continuation of concept):

Cost: $971,250
(See above for other information)

Channel I (continuation of concept):

Cost: $418,078
(See above for other information)

DAP Campaign - 1979 (continuation of concept):

Cost: $309,375
(See above for other information)

DAP Campaign Evaluation - 1979 (continuation of concept):

Cost: $149,907
(See above for other information)

CMA - Center for Multicultural Awareness (continuation of concept):

Cost: $473,000
(See above for other information)

New Initiatives:

Prevention Evaluation Resource Network: The purpose of this contract is to design a Prevention Evaluation Resource Network to assist States and local prevention programs to evaluate their prevention activities.

Cost:	$325,000	Target Category:	Health Promotion/ Antecedent Behavior
Target Area:	Environment	Intervention:	Evaluation

Demonstration Pilot Prevention Program (25 States): Commencing in Fiscal Year 1978, NIDA will fund the creation (cost shared with States) of a Prevention Coordinator position within 25 States. The project will be expanded to the other 25 States during this three-year plan and also will provide enhanced service delivery capability in the area of technical assistance, training materials development, and prevention, consultation needed by the State Prevention Coordinator to operate an effective Statewide drug abuse prevention system.

Cost:	$1.25 million	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Capacity Building

State Prevention Program Planning and Program Monograph: This effort will assist States in helping major local programs plan prevention efforts. It is a logical follow-on to the current planning effort at the State level (SSA). It might include three specific programs from each State working together through planning. This type effort will lead to consistency in planning from local to State to Federal levels.

Cost:	$220,000	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Capacity Building

Search Update and Curriculum Monograph: This effort will provide current knowledge of drug abuse prevention activities and assess current trends and practices at the local level, for subsequent dissemination to States and communities throughout the nation.

Cost:	$100,000	Target Category:	Health Promotion
Target Area:	Environment	Intervention:	Health Education

Prevention Evaluation Research Monographs: The development of three evaluation research monographs appropriate to process Outcome, and Impact Evaluation of drug abuse prevention programs.

Cost: $199,840 Target Category: Health Promotion
Target
Area: Environment Intervention: Evaluation

Family Publications: The development of drug abuse prevention materials appropriate to families (rural, low-income).

Cost: $ 67,297 Target Category: Health Promotion
Target
Area: Environment Intervention: Health Education

Division of Resource Development Utilization Study: A survey of NIDA publication Division of Resource Development utilization by the drug abuse community including prevention materials.

Cost: $ 40,000 Target Category: Health Promotion
Target
Area: Services Intervention: Research

Fiscal Year 1979*

PYRAMID (continuation of concept):

Cost: $500,000
(See above for other information)

Channel I (continuation of concept):

Cost: $400,000
(See above for other information)

CMA (continuation of concept):

Cost: $250,000
(See above for other information)

*The NIDA Prevention Budget for fiscal year 1979 has been reduced by OMB from $6.675 million in 1978 to $5.0 million in 1979. The funding level requested for FY 1979 by the Institute was $8.4 million. Due to these cutbacks, initiatives planned for FY 1979 will be dramatically reduced, cutback, or eliminated from program plans.

New Initiatives:

Prevention Evaluation Resource Network - Operational Phase: This contract will provide prevention evaluation service to State and local drug abuse prevention programs. There will be a consortium of four States working together to provide a central source for prevention evaluation.

Cost:	$500,000	Target Category:	Health Promotion/ Antecedent Behavior
Target Area:	Environment	Intervention:	Evaluation

NEW NIDA PREVENTION INITIATIVES:

FISCAL YEAR 1980 - 1982

A description of NIDA's prevention initiatives by objective follows. For convenience, all objectives are referenced to the goals to which they apply. Information relevant to an initiative's time frame, target area, target category, intervention, funding level, and funding mechanism are illustrated on a series of three charts or schematics; one each for Lifestyle, Services, and Environment.

Other data relevant to overall costs, staffing requirements and evaluation procedures are provided in the concluding paragraphs.

LIFESTYLES OBJECTIVES

1. Develop replicated service initiatives focused upon preventing youth (particularly teenage girls) from initiating and maintaining cigarette smoking behavior through the implementation of effective smoking prevention interventions. (Goal 1)

Rationale:

Epidemiologic data clearly indicates that the proportion of youth that initiate smoking behavior accelerates between the ages of 12 and 18; from 4 percent regular smokers to 32 percent at the age of 18 (Gritz, 1977). The rate of increase in smoking among teenage girls has increased substantially to the point that the proportion of girls who are regular smokers nearly equals the proportion of male teenage smokers.

A second concern magnifies the significance of smoking behavior among youth: the relationship of smoking behavior as a gateway drug to illicit drug use. The use of licit drugs (tobacco/alcohol) consistently precedes the use of illicit drugs by youth, with the first illicit drug of choice frequently being marihuana. Other drugs of abuse such as amphetamines, barbiturates, and tranquilizers can follow. While this pattern of drug use is not inevitable, it is clear that smoking and alcohol are gateway drugs for those youth who initiate the use of illicit drugs.

Given the detrimental effects of smoking behavior on physical health and the potential link of smoking behavior to the use of illicit drugs, a comprehensive smoking prevention research and development program is necessitated.

Initiatives:

The focus of this prevention initiative would be the identification and validation of a variety of drug abuse prevention strategies that have proven merit to smoking prevention among school age youth. The initiative would build upon what is already known concerning information, education, alternatives, and intervention prevention strategies and validate their effectiveness in the prevention of smoking behavior through controlled evaluative research studies. Primary attention would be given to those prevention strategies most effective in moderating peer pressure, parental and family modeling (of smoking behavior), and the development of information messages that counter the appeal of smoking as it relates to popularity, sexuality, social maturity and social fluency. This prevention initiative would build upon what is known from effective smoking prevention education programs (San Diego School Smoking Prevention Program, Houston Smoking Education).

The application of these strategies would not be limited to the school setting, but would include their utilization with youth serving agencies and groups (teen centers, boys' clubs, girls' clubs, 4H, etc.).

Five test communities would be involved in a national pilot test of a multi-modality smoking prevention approach to include a combination of information, education, alternatives and intervention strategies. "Positive prevention" strategies--in primary prevention would include "alternatives," values programs, decision-making curricula, peer counseling and modeling strategies, peer leadership techniques, interpersonal skills, and self-esteem enhancement programs. Five control communities would also be involved in the project for comparison purposes. These five communities would receive the smoking prevention "treatment" on a delayed basis. The validation phase of the project would occur over a three-year period at an annual cost of $2 million per year.

2. Assess the relationship between stress and drug use behavior by youth and validate effective drug abuse prevention strategies to assist individuals to better manage life-stress events. (Goals 1, 2)

Rationale:

Duncan's (1977) research with Halfway House adolescents indicates that drug abuse may be a stress-induced behavioral disorder. He found that on a measure of Life-Stress Events drug-dependent youth had significantly higher life-stress scores than non-drug-dependent youth. Stress events included: death of a family member/friend; downward shift in parental financial status; frequent arguments with parents; change in school; etc. Other researchers (Mayer, 1951; Holmes and Robe, 1967; Coddington 1972) have related the occurrence of stressful events (events that are beyond the capacity of the individual to deal with) with the onset of physical and emotional illness. The association of Type A personality factors with heart disease gives additional credence to the disabling effects of an individual's inability to successfully cope with stress-related pressures upon the individual and family.

Initiative:

NIDA will initiate a research effort to identify the relationship between life-stress events and individual coping strategies to these events with initial drug use behavior of youth. A national epidemiologic study of drug use patterns and life-stress events will be administered to a probabilistic sample of school age youth. The sample will be stratified on significant variables to include: population density, race and age. Initial drug use populations will be oversampled to insure a large enough sample size to identify and analyze life-stress events and coping strategies that differentiate drug-using and non-drug-using populations. The study will occur over a two-year time period at a total cost of $650,000.

Based upon the findings of the epidemiologic survey, the Prevention Branch will initiate the development and validation of several prevention interventions that show promise to better prepare youth to deal with life-stress events. The development and validation of these strategies will occur during the last year of this Forward Plan.

The developmental study will involve testing of at least three "coping to life-stress" drug abuse prevention programs. Annual program development costs are estimated at $550,000. A thorough process, outcome, and impact evaluation of all three program types will be initiated under separate contract. The total cost of the evaluation would be $150,000.

3. Strengthen parenting practices, family communication skills, and family coping abilities through the promotion of prevention research and prevention interventions. (Goals 1, 2, 4)

Rationale:

Drug abuse correlate research strongly indicates the influence of the family in the development of positive health attitudes and practices of children. Family factors that correlate positively with drug use on the part of youth include: parental use of drugs (Annis, 1971); parental medication use (Blum, 1972); parental permissiveness and lack of parental concern (Baer and Corrado, 1974); family instability and disorganization (Braucht, et al, 1973): and the quality of child-parent relationships (Braucht, et al, 1973).

Initiative:

Before meaningful prevention interventions can be developed for the family, much more needs to be learned concerning the influencing process of family life, particularly as it relates to parenting practices, family communication patterns, and family coping skills. Toward this end, NIDA will initiate a longitudinal (3 year) ethnographic study of 5 family cohorts with 20 American families per cohort group representative of Black, White, American, Indian, Hispanic, and Asian ethnic groups. Twenty families per cohort will be followed over the duration of the project, with data collection procedures following recommended ethnographic case study methodologies. These methodologies will explore in systematic and comprehensive fashion the development of family parenting practices, communication patterns and family coping skills to life-stress events and will relate these family activities to the development of youth living in these family environments particularly as it relates to drug use behavior. It is estimated that the ethnographic analysis of family patterns will have an annual cost of $450,000.

4. Promote among youth the acquisition of positive "risk management" skills to include sensitization to personal risk levels associated with drug use, development of appropriate drug-related decision making skills, and the initiation of self-protective health practices. (Goals 1, 2, 4)

Rationale:

Risk management is a relatively new approach to prevention and health promotion that attempts to identify target groups at risk of dysfunctional health events and modify those health behaviors that may lead to potential injury, illness, or disease. Interventions include promoting the awareness of risk levels associated with poor health behavior, development of appropriate decision making skills, and encouraging the personal initiation of self-protective health practices.

Risk management is a significant intervention for drug abuse prevention given the prevailing attitudes of youth toward the risk levels associated with drug abuse. Johnston, Bachman, and O'Malley (1977) in their survey of drug abuse behaviors of high school students, 1975-1977, report an alarming trend that fewer youth each year view drug taking as a high risk behavior that could do physical, emotional, or psychological harm. According to this survey, youth are slowly developing attitudes that tend to ignore the risk levels associated with drug taking across both licit and illicit drugs (alcohol, marihuana, through heroin).

The decline in the percentage of youth failing to associate drug use as a high risk behavior varies from one to seven percent across all drugs except cigarette smoking. With cigarette smoking, the survey reports more youth since 1975 indicating cigarette smoking behavior as placing an individual at "great risk" of doing physical or other type harm.

Initiative:

To counter this negative trend, NIDA plans to initiate a research and demonstration program to identify those factors associated with a youth's sensitization to the risk levels associated with drug use behavior and to validate appropriate prevention interventions to assist youth/families develop appropriate drug related decision making skills and self-protective health practices.

The most logical mechanism for the initiation of this process of awareness and skill building is the educational system. Modeling the approach of this initiative on the Georgia Life Skills Project, the school system will serve as the environment where awareness and skill building will occur and the community mental health center serving that local community will function as the mechanism to disseminate the training and conceptual development needed by teachers and the school administrators to implement this risk management model. This national prevention initiative will build upon the knowledge gained from the evaluation of the Georgia Life Skills Project that is currently being sponsored under a grant by the Prevention Branch. It is the intention of that program to utilize those life skills strategies that work most effectively in reaching youth and family members to become aware of risk levels associated with drug abuse and to develop better drug-related decision making skills.

NIDA's risk management prevention program will be pilot tested in 5 States during the first three years of this forward planning process. The project will be thoroughly evaluated to include a comprehensive process, outcome and impact assessment of program effects, with the evaluative data used to refine and more precisely develop the risk management model. The annual expenditure for the 3 year effort will be $700,000 per year.

DRUG ABUSE PREVENTION - SERVICE OBJECTIVES

1. Validate effective drug abuse prevention strategies (information, education, alternatives, and interventions) that meet the unique needs of special target groups (i.e., youth, minority populations, families, and the elderly). (Goals 1 - 5)

Rationale:

Drug abuse prevention programming is based upon correlate research that indicates that four factors are relevant to a youth's initial decision to use drugs: individual characteristics, family structure, peer relationships, and the influence of community institutions/environments.

Individual Factors

Braucht et al, (1973) found that certain personality characteristics were related to alcoholism and narcotics use. Drug users tended to score lower than non-users on a scale of general social conformity. This psychological measure indicates the individual's conception of himself as a person who conforms to the major mores of the United States culture. Braucht reported narcotic addicts to be "immature, insecure, irresponsible, and egocentric."

Jessor et al. (1973) found positive attitudes toward deviancy (socially unacceptable behavior) to be predictive of initial marijuana use.

Blum (1970 - 1972) supported the notion that those who initially tried drugs were not as well socialized to the traditional culture as those who did not use drugs.

Other research on individual characteristics and drug use has found that drug use is negatively correlated to feelings of self-worth (Smith and Fogg, 1975); feelings of belonging (Galli and Stone, 1975); religious beliefs, (Guinn, 1975; Jessor, 1971; Rohrbaugh and Jessor, 1975); and optimism about the future (Mellinger, Somers, and Manheimer, 1975). Drug use is positively correlated with sensation seeking (Segal, 1975); assertiveness (Horan, D'Amico, and Williams, 1975); impulsivity (Cisin and Calahan, 1968); and anti-social tendencies (Galli and Stone, 1975).

Family Factors

A second factor relevant to initial drug use is family life. A review of the literature relating initial drug use and family conditions finds that drug users: tend to come from families characterized by instability and disorganization; have experienced parental rejection; and, are either over-dominated or under-dominated by their parents (Braucht et al., 1973; Seldin, 1972). Research indicates that the important element of family life is the "quality of the relationship" established between the parents and the child, not just the presence of a parent in the home. Studies by Chein et al., 1964; Blum et al., 1969; and, Rosenberg, (1968-1969) suggest that the presence or absence of a parent is less important than the establishment of a positive parental (adult) relationship with the child. These researchers found that children from families: with a greater degree of cohesiveness; that respected social institutions; that were family-centered; and, that were not concerned with self-indulgence and short-range goals were less likely to be involved with drugs.

Another important aspect of family life is the parents' own use of drugs and the role model they provided to their children. Blum et al. (1970) found that 40 percent of the illicitopiate users reported that their parents used drugs. Smart and Fejer (1972) tested this hypothesis and found a positive association between reported drug use by parents and their offspring.

Peer Relationships

A third significant factor to the use of drugs by youth are peer relationships. Findings from correlation studies of peer usage patterns and a youth's decision to use drugs show that youths who try a variety of drugs are more likely to have friends that are also users of drugs. What is unclear from the research is whether drug-using friends encourage a youth to initiate drug use, or that a youth's friendships change after his initial drug use to include more drug-using friends, or the initially selected friends of a youth tend to have a high potential as a group for initial drug use. Gorusch and Butler (1976) provide an interesting review of some of the literature surrounding this research question.

Social Institutions/Environment

A fourth factor relevant to drug use relates to institutional influences to include the school, recreational program, and the general community. Correlate research from the fields of sociology and social psychology underscore the relationship between social environments and individual behavior. The theoretical work of Durkheim, 1897; Thomas and Znaniecki, 1927; and Shaw and McKay, 1942, illustrate that social disorganizations (anomie), a lack of consensus on social norms and weak ties among society's members can lead to deviant action (to include drug use behavior). Other theorists (Cloward and Ohlin, 1960; Southerland, 1974) propose that a gap between. aspirations and actual opportunity to realize personal goals may motivate delinquent sub-cultures (i.e., young formation) that promote social environments that accept and support socially disapproved behaviors. Following from this position, Cohen (1955) indicates the importance of the school environment as a source of youth frustration. Instead of assisting youth to attain personal aspirations, schools turn off youth from working toward socially desirable goals that could lead to success in life.

In general the research literature on these topics are extensive; this presentation is only attempting to capture a brief glimpse of the work to date. Though most theoretical research does exist, no one school of thought holds sway. Though most theorists agree that social influences do play some role in individual behavior, the exact nature of that relationship is the question for further research.

Initiative:

Over the three years of this Forward Plan, the Prevention Branch will encourage the development of drug abuse prevention grants that will rigorously test the effectiveness of a wide spectrum of drug abuse prevention strategies. To be eligible for funding under the Prevention Grants Program, grant applicants must demonstrate that the prevention strategy being tested has a strong theoretical basis and empirical support. In addition, the applicant must present a strong experimental or quasi-experimental research design (with control/comparison groups) that will form the basis for determining the effects of the prevention program on participants. Evaluative research of prevention programs directed at the individual (youth) peers of youth, families, school environment, and other social institutions (legal system, youth serving agencies, etc.) will have priority for funding. The annual cost of the grant program during this three-year plan is estimated at $3 million per year.

2. Replicate community-based drug abuse prevention strategies that have demonstrated validity for special target groups (i.e., youth, minority populations, families, and the elderly). (Goals 1 - 5)

Rationale:

The validation of drug abuse prevention strategies within one community or with one target group is but the first step in identifying prevention strategies that have merit for national replication. The second and equally important question to answer for NIDA is whether a specific drug abuse prevention model can be generalized from one setting to another and whether it has applicability to other target groups. The purpose of the replication studies will be to test the "transferability" and the "transportability" of effective prevention projects, materials, and processes from one community or special target audience to another. Since much is already known concerning the "diffusion of innovative programs", this research effort will build upon those findings (e.g., the need to establish local involvement in the planning process, the need for "hard-nosed" program administrators/managers, the essentiality of local buy-in to the concept from a funding perspective, etc.).

Initiative:

As innovative and valid drug abuse prevention strategies become available for testing, the Prevention Branch will promote a series of "replication" oriented grants (under the Prevention Grants Program) to test the generalizability of innovative prevention strategies. Each replication study will thoroughly assess the effect of the program on the drug abuse attitudes and behaviors of program participants as well as thoroughly document the diffusion process that occurred when that particular prevention program was adopted/adapted by the new target community.

During the course of this Prevention Plan special attention will be given to the replication of drug abuse prevention strategies that meet the unique needs of minorities, youth, families, the elderly, and women. The annual cost of these replication grants are estimated at $2 million.

3. Promote greater participation in drug abuse prevention of national and local youth-serving agencies to act as catalysts for community-based drug abuse prevention programs. (Goal 5)

Rationale:

Effective drug abuse prevention programming begins with intelligent planning and implementation that involves various governmental and local agencies. Consistent with the recommendations of the White House Sub-Committee on Prevention, this three-year planning process acknowledges the differentiated prevention role of Federal, State, and local government and community agencies. A definition of these roles follow:

a. The Federal role should be one of leadership and national catalyst. Because of the resources available, it is also in a unique position to take an aggressive role in human resource development, including impact research and evaluation. Further, the Federal Government is the only entity which can marshal adequate resources to assure that an adequate knowledge development strategy is promoted. Finally, it can collaborate in the targeting of resources and the technical assistance and planning necessary for the effective use of such resources.

b. The States should collaborate in the leadership role and be the primary resource targeting and program coordination mechanism. Further, the States, along with local governments, should become the primary source of service delivery resources (both human and fiscal) and should be the most active level of program operation. Additional activities should include issuing tailored training guidelines and dissemination information.

c. The local communities should be the primary deliverers of services. This includes the ability to organize, to identify local resources, and to operate programs. They would share primary funding responsibilities with the States as well as share the responsibility for resource targeting and program coordination.

The delivery of cost-effective drug abuse prevention programs is founded upon local community collaboration, cooperation, and capacity building. The community institutions most relevant to the prevention of drug abuse are youth-serving groups or agencies. These groups are already in-place in many communities, have wide appeal and acceptability by both youth participating in the programs and by citizens of the communities being served, and have access to a large volunteer-based resource that form the nucleus of that community's prevention service delivery capability.

Initiative

NIDA will build upon its current Catalyst project and will extend the building of a national prevention consortium of youth-serving agencies to participate in the planning, implementation and resource development needed for effective community-based drug abuse prevention programs. The purpose of this initiative will be to create an awareness on the part of the decision-makers of youth serving agencies of the role for these agencies in the prevention of drug abuse and health promotion. It is the intention of this initiative to facilitate the involvement and coordination of national and local youth serving agencies in the active delivery of prevention services at the national and local level.

The annual cost of this effort will be $250,000 over the duration of this Prevention Plan.

4. Encourage the private sector to take a more active role in drug abuse prevention through the sponsorship of employee drug abuse prevention programs and by corporate participation in community-based drug abuse prevention programs at the national and local level. (Goal 5)

Rationale:

No other force is so pervasive in our society as the private sector. Private corporations, businesses, and industry form the backbone not only of our economic system but also our social system. Business groups, fraternal associations, unions, alliances of business men, etc., have a long history of active involvement in community projects to improve the social well-being of local neighborhoods, cities, and towns. The purpose of this prevention objective is the "focusing" of this vital force on the problems associated with drug use and the prevention of drug abuse in local communities across the nation. Involvement of these groups in both the molding of public opinion and the development of within community funding sources is required if drug abuse prevention programming is to be viable at the local level.

Initiative:

NIDA will establish strong alliances with representatives of the private sector and promote their active involvement in drug abuse prevention programming. This initiative will involve carrying the drug abuse prevention message to the private sector; formation of private sector advisory groups at the National, State, and local level; and, the development of corporate drug abuse prevention programs that directly meet the needs of troubled employees.

This initiative would build upon NIDA's current Channel One Project which actively involves the Prudential Insurance Company in the development of prevention programming at the local level. This project is currently being pilot tested in HEW Region I (New England and New York). Preliminary findings indicate that program collaboration between the private sector and the Federal Government can lead to prevention programs that directly benefit the communities participating in these efforts.

The annual cost estimate for this new initiative for FY 80 - 82 is $500,000 per year.

DRUG ABUSE PREVENTION-ENVIRONMENT OBJECTIVES

(SYSTEM ENHANCEMENT)

1. Promote the development of effective drug abuse prevention programs at the State level by increasing the capacity of Single State Agencies for Drug Abuse to plan, implement, and monitor drug abuse prevention programs. (Goal 5)

Rationale:

NIDA's primary partner in drug abuse prevention is the Single State Agency for Drug Abuse. Currently drug abuse prevention programming at the State level requires additional planning, programming, and evaluation capacities that are vitally needed by States to institute and monitor meaningful drug abuse prevention programs. At present, the development of these capacities is hampered by the lack of adequate State funding allocations in prevention, the lack of qualified drug abuse prevention personnel within the State system, and the need for greater collaborative drug abuse prevention programming between NIDA and the States.

Initiative:

Commencing in Fiscal Year 1978, NIDA will fund the creation (cost shared with States) of a Prevention Coordinator position within 25 States. The project will be expanded to the other 25 States during this three-year plan and also will provide enhanced service delivery capability in the area of technical assistance, training materials development, and prevention, consultation needed by the State Prevention Coordinator to operate an effective State-wide drug abuse prevention system.

The cost of the State Partnership Program will be $2.6 million for the three years of this Prevention Plan.

To enhance the operation of the Prevention Coordinator's Program, NIDA will also support several prevention training initiatives. The field of drug abuse prevention lacks a comprehensive statement of professional standards for drug abuse prevention workers. Currently, little is known about the specific roles, responsibilities, or tasks performed by those who consider themselves drug abuse preventors. More importantly, even less is known about the needed qualities and qualifications of those preparing to work in the field of drug abuse prevention.

More needs to be known concerning the specific skills and knowledge needed by the professional drug abuse preventor in order that prevention training and advanced degree programs can best be designed to meet the educational needs of the field.

Toward this end, a Prevention Standards initiative will be established. The purpose of this effort will be to define specific job functions and tasks performed by drug abuse prevention professionals and to identify the training/educational requirements that should be met by those desiring to work as a Drug Abuse Preventor at the State or local level. The total cost for this two year initiative would be $180,000.

Upon completion of the Professional Standards project, NIDA would then support a Prevention Professional Continuing Education Program to be operated at the State level to support the professional preparation of those preventors currently working in the field and to prepare individuals to enter the field of drug abuse prevention. Continuing education funding would be channeled through the SSA through a competitive contracting process. The estimated operational costs for the year would be $500,000 (approximately $10,000 per State).

2. Coordinate the systematic evaluation of drug abuse prevention programs at the National, State and local level. (Goals 1, 2, 3, 4)

Rationale

Fundamental to effective drug abuse prevention efforts is the evaluation of the effects of prevention programs on participants and upon the quality of health of the community being served by prevention programs. The Evaluative Research Model promoted by NIDA attempts to systematically capture this vital assessment data at the three evaluative levels: Process Evaluation, Outcome Evaluation, and Impact Evaluation. Process evaluation involves the assessment of the operation of a prevention program to include the description of services delivered, utilization of resources, qualification/experience of personnel, etc. Outcome evaluation involves the measurement of the effects of an individual prevention program on the drug-use attitudes, interests, knowledge, perceptions, and behaviors of the participants in that program. Impact evaluation unlike the preceding two evaluation types involves the assessment of the aggregate or cumulative effect of drug abuse prevention programs operating within a community as measured by some set of community-wide drug use indicators (e.g., incidence and prevalence studies, DAWN data, school-wide drug use surveys, etc.).

Each of the three levels of the Prevention Evaluative Research Model are logically linked. Process evaluation provides a thorough description of the prevention "treatment" being offered to a community. Outcome evaluation assesses the effect of the prevention strategy on participants. While Impact Evaluation attempts to link the operation of effective drug abuse prevention programs within a community to changes in the overall health status of that community as measured by appropriate health indicators.

To date, the evaluation of drug abuse prevention programs has occurred on a catch-as-catch-can basis. Reinventing the "prevention wheel" frequently occurs at the expense of local drug abuse prevention programs. A need exists to develop a centralized evaluation capability that will identify and apply the state of evaluation research art to the assessment of drug abuse prevention programs at the State and local level.

Initiative:

Consistent with this need, NIDA has established as a priority the development of a prevention evaluation capability. The first project (Fiscal Year 1978) involves the design, development, and pilot testing of a Prevention Evaluation Resource Network to provide States with the technical assistance, capacity building, and consultant expertise to perform process, outcome, and impact evaluations of their prevention programs. The purpose of this contract effort is to design and pilot test a prototype of this prevention resource network in a sample of four States. The design and pilot testing is scheduled for completion in October 1979. Upon finalization and refinement, the Prevention Evaluation Resource Network would become operational for utilization by State and local drug abuse prevention programs. The annual cost of operation and network through FY 1980 - 1982 planning period would be $1 million.

3. Transfer "proven" drug abuse prevention technologies (technical assistance, prevention materials, prevention techniques, and processes) to States, local communities and individual drug abuse prevention programs attempting to establish more effective community-based drug abuse prevention programs. (Goals 1 - 5)

Rationale:

While direct funding of drug abuse prevention services is primarily the concern of States and local communities, the transfer of proven prevention technology is a primary objective of NIDA. These technologies include technical assistance, dissemination of prevention program materials, consultant expertise, and program information. This "technology transfer" capability is vitally needed by the field of drug abuse prevention if the drug abuse prevention service delivery providers are to continue to deliver effective prevention programs to youth, parents, and families in their communities.

Initiative:

Over the last three years, NIDA has developed a technology transfer expertise and dissemination mechanism through two major projects: The Pyramid Project and the Center for Multi-Cultural Awareness. The Pyramid Project is designed to share current theoretical developments in the prevention field as well as practical experience derived from successful prevention programs, suggest ways of amassing information about the acceptance of prevention efforts, provide consultation on evaluative techniques and other prevention programming requirements, share relevant research findings and designs, and assist in the identification of video tapes, film and other media.

The Center for Multi-Cultural Awareness provides on-site technical assistance to minority programs and the development and dissemination of prevention materials appropriate to the unique needs of minority groups. During the three-year plan, NIDA will continue these two model technology transfer programs as well as the development of other technology transfer capabilities, e.g., a national search of successful drug abuse prevention programs and educational health curricula, the development of video models of validated prevention programs, etc.

The annual cost for Project Pyramid is estimated at $700,000 per year. The annual cost for Multi-Cultural Awareness Center would be $300,000 per year. The annual costs of other related technology transfer projects (e.g., video tape models, cost benefit analytic approaches) are estimated at $250,000 per year.

4. Develop and validate public education initiatives that alert the general public, families and professionals to the roles that each can play in preventing drug abuse. (Goals 1 - 5)

Rationale:

Public education programs are one of the most valuable drug abuse prevention strategies available to NIDA. Through public information programs, individuals, parents, families, peers, as well as professional groups to include the medical community can be reached and informed about the drug abuse problem. More importantly, public education can assist individuals, groups and professional groups realize they too have a role to play in drug abuse prevention. The cost benefit of the use of media campaigns and wide spread dissemination of effective prevention materials has demonstrated merit.

Initiative:

Three major efforts will be conducted during the three-year planning process to include the continuation of annual national drug abuse prevention campaigns, the development of a series of specialized drug abuse campaigns directed at the medical profession (e.g., general practitioners, family practitioners, psychiatrists, and internists concerning the use of sleeping pills), and the development of prevention materials appropriate for youth, peers of youth, and family members. Those materials will be disseminated through the educational system.

The purpose of the annual drug abuse prevention campaign is to heighten public awareness concerning the problem of drug abuse and to illustrate the role that each individual can play in the prevention of drug abuse. This campaign effort will build upon the public education programs initiated by NIDA in 1978 and 1979. Process, Outcome, and Impact evaluations of prevention campaign effectiveness will also be initiated.

The annual costs of this series of prevention campaigns is estimated at $300,000 per year. The annual cost of each campaign evaluation is estimated at $175,000.

Relevant to professional groups, NIDA is attempting to further reduce the annual number of sleeping pill prescriptions written for barbiturate and nonbarbiturate, nonbenzodiazepine drugs by initiating a physician and public education campaign. Although there has been a 35 percent decline in the total number of annual prescriptions for sleeping pills in 1976, there were still approximately 14 million prescriptions for other drugs which are potentially more dangerous, probably less effective for chronic use, and more often associated with abuse than some of the more recently manufactured sleeping pills. Such a preventive effort would result in further reducing the morbidity and mortality associated with the use of sleeping pills by reducing the total availability of these drugs through licit channels. The proposed target population will be physicians, primarily general practitioners/family practitioners, psychiatrists and internists (our data sources indicate that these specialists prescribe the majority of the sleeping pills), and the general adult public. NIDA's share of this three-year project is $200,000.

Related to these general and specific prevention campaign initiatives is a research initiative that will assess the impact of prevention-related radio and television programmers on drug-use behavior of selected target populations; measure the long-term effects of attitude change on drug-taking behavior; and assessment of impact of different prevention message-types on the incidence and prevalence of drug abuse within a target community.

This two year study will investigate the communication factors that are associated with effective prevention campaign programming and will establish a model campaign strategy based upon empirical data derived from previous evaluations of NIDA prevention campaigns.

The total cost for this project will be $625,000.

The fourth initiative involves the development of appropriate drug abuse prevention literature (pamphlets, flyers, posters, games, etc.) that will be directly disseminated through the educational system and through participating youth-serving agencies. Youth, peers of youth, and families require accurate and readable information regarding the risk levels and problems associated with drug use, drug mis-use, and drug abuse. This initiative will build upon the prevention campaign materials previously developed and establish a direct dissemination system to those in need of drug abuse prevention information and assistance.

The estimated annual cost of this material development and dissemination is $450,000.

NIDA DRUG ABUSE PREVENTION FORWARD PLAN
FISCAL YEAR 1980 - 1982: PREVENTION PROGRAM SCHEMATIC (LIFESTYLES)

INITIATIVES	TARGET CATEGORY	TYPE OF INTERVENTION	FUNDING	PROJECT PHASING	FUND MECH
1. Smoking Prevention	Health Promotion	Services Demonstration	$2 Million/Year	1980-82	Contr
2. Coping with Life-Stress Events					
• epidemiologic survey (life-stress coping and drug use (behavior)	Health Promotion	Research	$650,000 Total	1980-81	Contr
• validation of three model coping programs	Health Promotion	Services Demonstration	$350,000/Year	1981	Contr
• Three year evaluation of model programs	Health Promotion	Evaluation	$150,000 Total	1982	Contr
3. Family Health Promotion					
• ethnographic study of families	Health Promotion	Research	$450,000/Year	1980-82	Contr
4. Risk Management Skills					
• Pilot test of risks Management program in five States	Health Promotion	Services Demonstration	$700,000/Year	1980-82	Contr [illegible]

NIDA DRUG ABUSE PREVENTION FORWARD PLAN
FISCAL YEAR 1980 - 1982: PREVENTION PROGRAM SCHEMATIC (SERVICES)

ITIATIVES	TARGET CATEGORY	TYPE OF INTERVENTION	FUNDING	PROJECT PHASING	FUNDING MECHANIS
Validation of Effective Drug Abuse Prevention Strategies • Individual • Family • Peer Group • School • Other Social Institutions	Antecedent/Consequent Behavior	Services Demonstration	$3 million	1980-82	Preventio Grants Pro
Replication of Effective Drug Abuse Prevention Strategies • Individual • Family • Peer • School • Other social institutions	Antecedent/Consequent Behavior	Evaluation (Replication)	$2 million/yr	1980-82	Preventio Grants Pro
Catalysts for Community-Based Drug Abuse Prevention Programs • Youth-serving groups	Health Promotion	Services Demonstration	$250,000/yr	1980-82	Contract
Private Sector Alliance Building	Health Promotion	Services Demonstration	$500,000/yr	1980-82	Contract

FISCAL YEAR 1980 - 1982: PREVENTION PROGRAM SCHEMATIC [illegible]

INITIATIVES	TARGET CATEGORY	TYPE OF INTERVENTION	FUNDING	PROJECT PHASING	FUNDI MECHA
1. Capacity Building for the Single State Agency for Drug Abuse	Health Promotion				
• State Prevention Coordinators		Capacity Building	$2.6 million/ yr.	1980-82	Contr State
• Professional Standards		Training	$180,000 (total)	1980-81	Contr
• Prevention Continuing Education Program		Training	$500,000/yr.	1982	Contr State
2. National Prevention Evaluation Resource Network	Health Promotion/ Antecedent Behavior	Evaluation	$1 million/yr.	1980-82	To be decid
3. Technology Tranfer	Health Promotion				
• Pyramid		Capacity Building	$700,000/yr.	1980-82	Contr
• Center for Multicultural Awareness		Capacity Building	$300,000/yr.	1980-82	Contr
• Special Projects (Video models, Cost benefit models, etc.)		Capacity Building	$250,000/yr.	1980-82	Contr
4. Public Education					
• National Drug Abuse Prevention Campaign	Health Promotion	Health Education	$300,000/yr.	1980-82	Contr
• Sleeping Pill Campaign	Health Promotion	Health Education	$200,000 (total NIDA share)	1980-82	Contr
• Campaign Evaluations	Evaluation	Evaluation	$175,000/yr.	1980-82	Contr
• Attitude Assessment	Evaluation/Research	Research	$625,000 (total)	1980-82	Contr
• Prevention Materials Develop.	Health Promotion	Health Education	$450,000/yr.	1980-82	Contr

Total Costs and Manpower Requirements

A cost breakdown for fiscal years 1978 - 1982 are illustrated in the following chart.

Annual Total Costs
(in millions)

Fiscal Year

	1978	1979	1980	1981	1982
Lifestyles			$3.475	$3.825	$3.300
Services			5.750	5.750	5.750
Environment			6.139	6.139	6.549
TOTAL	$6.675	$5.090	$15.364	$15.714	$15.599

To effectively initiate NIDA's Forward Planning effort a 40 percent increase in existing professional and support staff is required. Though projected programs expenditures are substantially greater than current funding levels, a corresponding increase in NIDA prevention staff is not required because:

a. Of an increased role of State drug abuse prevention personnel in national programming;

b. projects, such as Project Pyramid, and the Center for Multi-Cultural Awareness shift the demand for technical assistance, information, etc., from NIDA prevention staff to prevention expertise mobilized by these contract efforts.

Evaluation

The evaluation of NIDA prevention programming involves the sponsoring of evaluation contracts specific to selected prevention initiatives (e.g., evaluation of the Drug Abuse Prevention Campaign) and extensive program monitoring practices implemented by NIDA Prevention staff.

To insure professional contract and grant monitoring, NIDA Prevention staff will update their knowledge concerning changes in NIDA/ADAMHA procurement policy and practices and will participate in regularly scheduled staff reviews of project accomplishments to be conducted at the Branch level.

Finally, epidemiologic surveys of drug use prevalence and youth attitudes towards drugs will be closely scrutinized to determine any changes in drug use patterns/drug use attitudes that had been the focus of NIDA Prevention initiatives. In this way, progress toward the accomplishment of Prevention Goals and Objectives will be monitored and where necessary modifications in program planning enacted in order to better respond to change in drug use behavior.

Evaluation activities in the area of effectiveness of NIDA funded treatment:

The Drug Abuse Community Programs Evaluation Summary provides a significant amount of data relating to the activities that pertain directly to the delivery of treatment services (see Attachment A). The Division of Research and the Division of Resource Development have funded, and are currently funding, a number of studies which specifically examine what happens to a client after he or she terminates from treatment. The most extensive study, originally conceived in 1968, is the Drug Abuse Reporting Program and its followup studies. The Institute of Behavioral Research, Texas Christian University, and the National Institute on Drug Abuse have collaborated for over a decade in this treatment outcome study. At present, five year followup data is available on a cohort or sample of clients that received treatment in federally-funded treatment programs during the years 1969-1972. Basic demographic data were collected on this followup sample, and a critical examination was made of performance variables, prior to, while in, and subsequent to receiving treatment. These performance variables include: opioid use, non-opioid use, marijuana use, alcohol use, and employment, months employed, arrest rate, any jail and any drug treatment. Figures 1, 2, and 3 graphically represent these variables, comparing the immediate pretreatment period with the performance one year post treatment. In all treatment groups, including detoxification, and intake only there was a significant decrease in the frequency of opioids consumed. Non-opioid use decreased significantly only in the methadone maintenance, therapeutic communities and drug free outpatient modalities. Marijuana increased significantly only in the methadone maintenance treatment programs. This may be explained by the relatively long period of time the clients spent in treatment, such that their post treatment use of marijuana reflects the trend for its more common use in more recent years, rather than as a direct result of treatment. The increase in alcohol may reflect substance substitution. There appears to be very little change in employment when one compares the year before treatment with the years subsequent to treatment. However, there is a significant increase in the number of months employed post treatment in methadone maintenance, drug free outpatient, and therapeutic communities when pretreatment levels are compared to post treatment levels.

Arrest rates significantly decreased after treatment in methadone maintenance treatment programs. Any jail for the year prior to treatment is not available and, therefore, pretreatment vs. post treatment incarceration rates cannot be calculated. Clients return to treatment.

Nearly half of the clients initially in treatment in the years 1969-1972 have had at least one subsequent treatment episode. It appears to take time, and several treatment experiences before drug abusers, especially drug abusers with a primary problem of opiate abuse, improve sufficiently that they no longer abuse drugs and need treatment.

A more detailed analysis of clients in methadone maintenance programs is presented in Attachment B. It serves to illustrate the comprehensive evaluation activities which can and are being produced by the National Institute on Drug Abuse.

The National Institute on Drug Abuse is currently developing a new clinical investigation study to provide a more critical understanding of client behavior while in federally funded treatment programs, and subsequent to treatment. The Treatment Outcome Prospective Study (TOPS), its followup activities and special studies will permit a long term systematic understanding of the natural history of drug abusers. The study is currently in the field test-pilot phases. This study is systematically examining the demographic variables, treatment process, performance variables, and community impact of methadone maintenance methadone detoxification, therapeutic communities and drug free outpatient programs in six geographically diverse cities. The field test activities in Chicago and Des Moines have indicated that long range studies are feasible if clinic and client cooperation is negotiated during the initial phases of the study. This study is a "state of the art" approach to clarifying and defining the numerous concepts and precepts which are currently dealt with under the rubric of drug abusers and drug abuse. The systematic followup studies of clients who prematurely terminate treatment will permit the appropriate modification of treatment programs to decrease the percent of early splitees, if this is found appropriate. At present, there is no clear understanding as to why clients leave treatment prematurely, and whether they do as well as, or more poorly than their counterparts who remain in treatment for longer periods of time. Preliminary quantitative data will not be available until mid-1979.

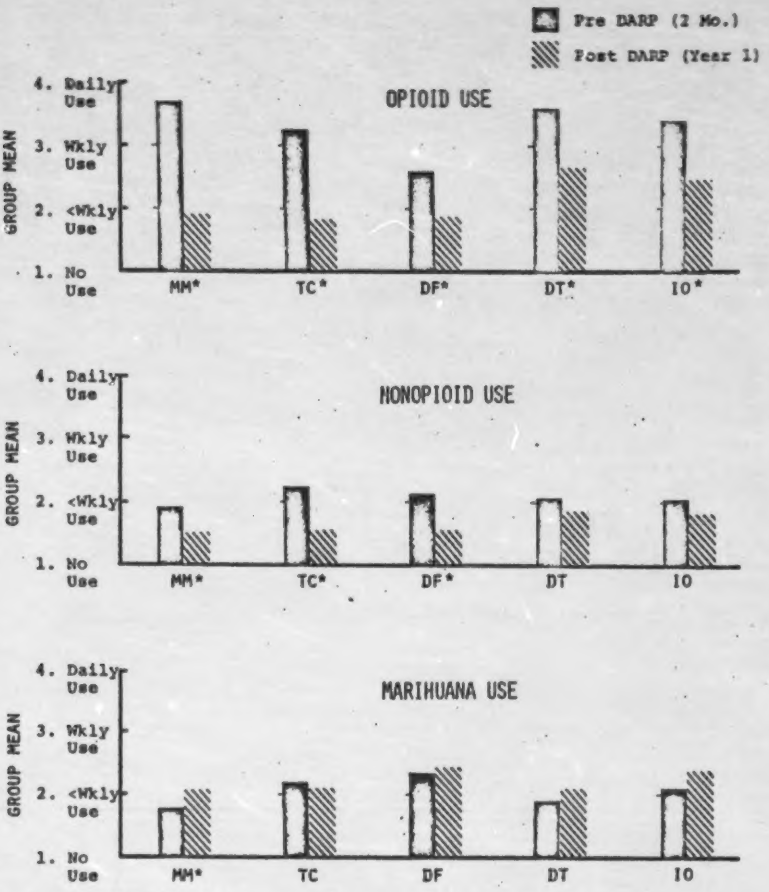


Figure 1. Illicit drug use before and after DARP treatment for each treatment group. (Asterisks denote groups with statistically significant changes, $p<.01$.)

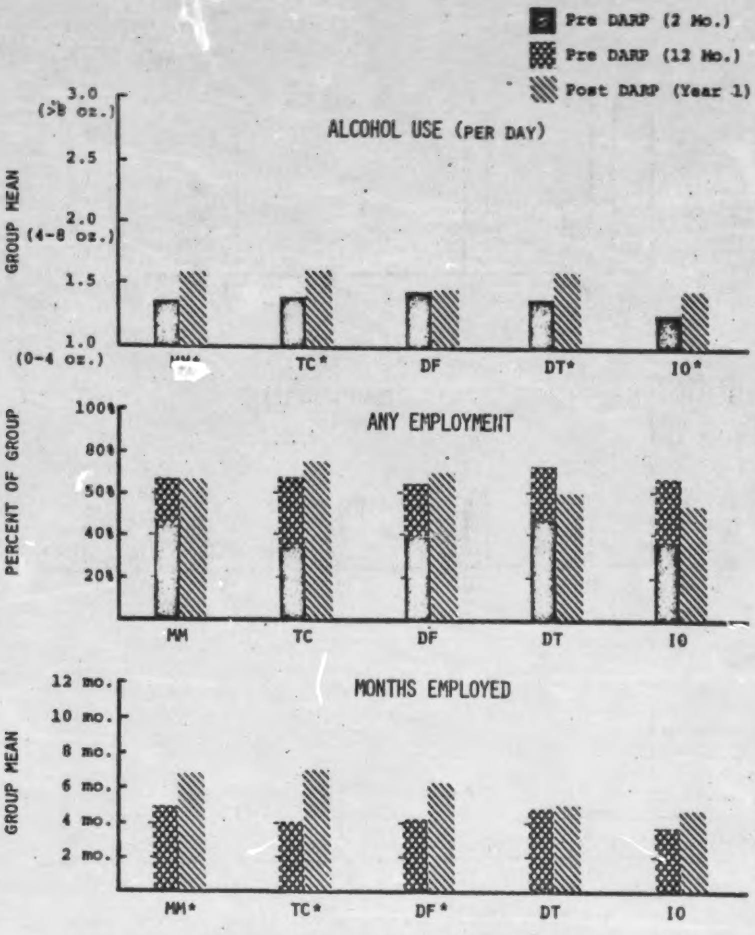


Figure 2. Alcohol use and employment before and after DARP treatment for each treatment group. (Asterisks denote groups with statistically significant changes, p<.01.)

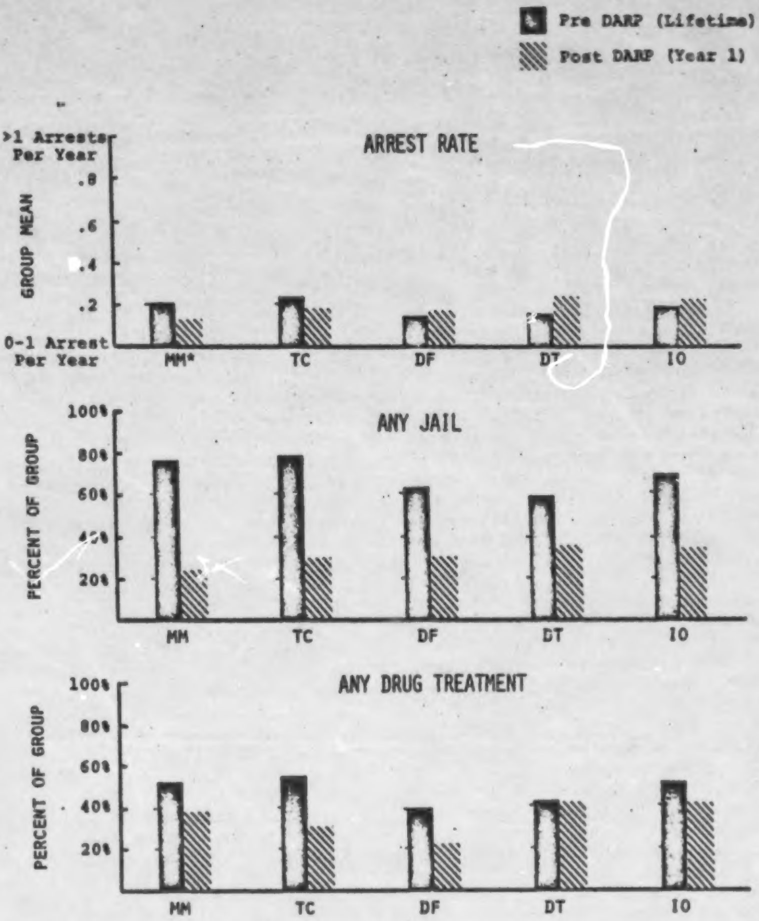


Figure 3. Criminality indicators and drug treatments before and after DARP treatment for each treatment group. (Asterisks denote groups with statistically significant changes, p<.01.)

Attachment A

DRUG ABUSE COMMUNITY PROGRAMS EVALUATION SUMMARY

I. Background and Introduction

Through the drug abuse project contracts and grants funded under Section 410 of P.L. 92-255, the National Institute on Drug Abuse (NIDA) administers a comprehensive program of drug abuse treatment services throughout the United States. The NIDA budget recognizes that the Federal government must continue to share a large burden of the effort in treating drug addicts and abusers. NIDA is committed to maintaining 102,000 drug treatment slots throughout the nation in fiscal year 1978. These slots are currently funded with a matching Federal share decreasing to a minimum of 60 percent Federal funding, with the intent that the Federal share will be maintained at 60 percent. The primary mechanism through which treatment services are funded by NIDA is the statewide services contract (SWSC). The statewide services contract is a cost-reimbursement/cost-sharing contractual mechanism generally with, or through, Single State Agencies for Drug Abuse (SSAs) under which local drug treatment programs are subcontracted. The prime contractor has the responsibility for the administration and coordination of those treatment services. This mechanism allows for treatment services to be delivered within a state under the authority of the agency generally responsible for drug abuse planning and coordination for the state. The SWSC funding mechanism and the treatment slot concept are, within the PHS, unique to NIDA. A level of sophistication has been achieved in the field of drug abuse treatment which enables NIDA to require programs to comply with a specific statement of work which includes the Federal Funding Criteria for Treatment Services (FFC), and this is the rationale behind the use of the contract mechanism. The treatment slot concept itself provides for stability of funding and is an uncomplicated, flexible concept to administer. It also provides for ease of monitoring and continuity of funding. In fiscal year 1977, 73 percent of NIDA's drug abuse community services program budget of $138,182,000 was awarded through contracts ($92,795,000 through SWSCs, and $7,684,000 through direct contracts) while the remaining 27 percent was awarded through direct service grants. It is anticipated that by fiscal year 1980 virtually all of these funds will be awarded by means of contracts. Drug treatment services can also be funded under the State Formula Grant mechanism, authorized by Section 409 of P.L. 92-255, which is also administered by NIDA. NIDA administered $40,000,000 in formula grant funds in fiscal year 1977. SSAs, in keeping with their State Drug Abuse Plans, can expend monies from their formula grant allocation for drug treatment services. While this mechanism provides the SSAs with monies which can be used in furtherance of their Drug Abuse State Plan, it does not have the same accountability required under the contract mechanism.

II. Federal Policy Relevant Knowledge

1. Services Effectiveness

- NIDA funded drug treatment programs have maintained a high utilization rate for their drug treatment slots. NIDA reviews program utilization on a quarterly basis and has the ability to move underutilized capacity to areas of maximum need.

- The most recent review (October of 1977) showed an overall utilization rate for NIDA-funded drug treatment programs of 88 percent.

- The major modalities used in the treatment of drug abuse are: detoxification, drug free, and methadone maintenance. The major settings are: inpatient, residential, outpatient, and day care.
  - NIDA funds all of these modalities and settings.
  - NIDA is currently examining the impact of LAAM on drug treatment services. LAAM is a longer acting form of methadone which requires fewer visits to the program for medication and reduces the need for take home medication.

- In order to maintain the quality of treatment services, NIDA has to account for the impact of inflation.

- The maximum ceilings for NIDA participation in fiscal year 1978 are: Inpatient - $40,000; Residential - $5,400; Day Care - $2,500; and Outpatient - $1,850.

- The majority of NIDA-funded treatment slots are in the outpatient setting and the smallest percentage of NIDA-funded treatment slots are in the inpatient setting.
  - The quarterly reviews for October 1977 showed that of the total NIDA funded community program treatment slots: over 83 percent were in the outpatient setting; over 11 percent were in the residential setting, less than 1 percent were in the day care setting, and less than 1 percent were in the inpatient setting.
  - Thus, the primary settings utilized are those with the lowest associated costs.

- NIDA will continue to focus on strengthening its current system by: assisting SSAs in the improvement and enhancement of their management and monitoring capability; by working with programs to improve and enhance their documentation of client records; and by developing and distributing guidance manuals on various management and treatment topics.

- NIDA will also be examining possible modifications to the existing treatment slot concept (e.g., slot concept with increased contact required, high intensity/low intensity outpatient modalities) to maximize its impact and effectiveness. NIDA will also be examining other possible funding options (e.g., slot funding base with fee-for-service increments, full fee-for-service). NIDA will develop specific evaluation criteria for this examination. These options will be measured against NIDA objectives and their impact on the total delivery system (e.g., manpower, costs, etc.) will be measured.

2. Costs and Efficiency

- Alternative sources of funding are minimally available at this time, and there is a critical need to maintain the current level of drug abuse treatment services. Some States and programs have had difficulty in meeting match requirements and, therefore, the 60 percent Federal floor must be maintained.

- Currently, patient fees and third-party reimbursements are only sufficient to supplement funding.

- NIDA has been working to have drug abuse treatment services become more accepted by, and integrated into, the general health care delivery system.

  - NIDA encourages SSAs to develop licensure standards, and has funded the JCAH project which led to the development of the JCAH self-improvement/accreditation program for drug abuse treatment programs. (The JCAH accreditation standards represent the maximally achievable standards for drug abuse treatment services). We encourage programs to participate in the JCAH self-improvement/accreditation program.

  - NIDA has also been working with private insurers such as Blue Cross-Blue Shield to develop model benefit packages for drug abuse treatment.

  - We have also been working with ADAMHA to impact on the development of National Health Insurance (NHI) so that ADM services may be included.

- While we are working with programs, through the provision of consultation and technical assistance, to maximize third-party reimbursement, NIDA must remain the backbone of the treatment system until such a time as other financial mechanisms can be developed which can maintain the viability of this system.

- NIDA has controlled costs by establishing ceilings for Federal participation in the funding of drug abuse treatment services.

- We recognize, however, that, on the whole, we do not fund the total costs of drug abuse treatment services. While it is not our intent to fund the total costs, we must continue to allow for the factor of inflation if the quality of drug treatment services is to be maintained and enhanced, and if the current level of treatment services is to be maintained. Without these, there can be no hope of integration of drug treatment services into the general health delivery system, nor of continuing to meet the existing demand for services.

3. Management

- NIDA has developed a strong management system to administer the drug abuse community projects it funds. It has developed a capacity to monitor, review, and provide technical assistance to these projects.

- The Institute has also taken the lead in the issuance of various manuals which provide program guidance in critical areas.

- The statewide services contract itself allows for the establishment of specific requirements, including the FFC, within the contract scope of work with which programs must comply. The contract also specifies services to be delivered by modality/setting and, therefore, provides a base against which performance can be measured.

- NIDA, through both an in-house and a contractual capability, will continue to provide individual program monitoring, program management reviews (which are designed to clearly define the management strengths and weaknesses of programs and to isolate areas needing attention), technical assistance, and consultation.

- The Institute has issued a Statewide Services Contract Policy and Practice Manual, a Statewide Services Program Review Manual, and we are developing a Program Development Specialist/Project Officer Statewide Services Contract Monitoring Manual. We have issued a Program Self-Evaluation Manual, and we are developing a Patient Record Keeping Manual and a Detoxification Manual.

- The Federal Funding Criteria established minimum treatment standards to which NIDA treatment programs funded under Section 410 of P.L. 92-255 must comply, and we are encouraging programs to work toward the development of maximum standards through participation in the JCAH self-improvement/accreditation program.

- Through NIDA's established management system, program deficiencies can be, and have been, identified and then resolved.

- NIDA will continue to work with SSAs to improve and enhance their management and monitoring capabilities, and with programs to improve their documentation of client records. We will also work to further develop the effectiveness of the statewide services contract and the treatment slot mechanisms through improvement in the RFP language and reporting requirements.

4. Reform Initiatives

- NIDA will continue to work toward acceptance of drug abuse as a chronic disorder with legitimacy in the total health care system as exemplified through coverage by third-party payors and inclusion in any National Health Program which is developed.

III. Alternative Interpretations and Perspectives

- There are those who would like to see NIDA directly contract with, or through, cities in which there is a NIDA-funded drug treatment program.

- There are those who would like to see NIDA fund directly through a block grant mechanism.

- There are those who would like to see NIDA immediately change its funding from a cost-reimbursement/cost-sharing mechanism to another mechanism such as a fee-for-service contract.

- There are those who would like to see NIDA expand its focus from the funding of community-based drug treatment programs to the funding of drug treatment programs in jails and prisons.

IV. Sources

DRUG ABUSE REPORTING PROGRAM FOLLOW UP STUDIES Attachment B

The Drug Abuse Reporting Program (DARP) is a joint National Institute on Drug Abuse (NIDA) Institute of Behavioral Research (IBR), Texas Christian University (TCU) effort which commenced in 1968. During its intreatment assessment period, it collected admission and intreatment data on approximately 44,000 clients entering and being treated in the newly established Federally funded drug abuse treatment network. The admission data included baseline performance measures, as well as demographic information. The intreatment data included performance measurements in two-month intervals, permitting trend analysis by modality, environment, and time. The intreatment assessment period lasted for four years and the data has been grouped into three cohorts: Cohort 1, the admissions during the 1969-1971 period represent primarily methadone maintenance clients; Cohort 2, the admissions during 1971-1972 represent methadone maintenance clients, as well as therapeutic community and drug-free outpatient clients; Cohort 3, the admissions during the 1972-1973 period represent all principal modalities. At present, there have been follow up studies completed on Cohorts 1 and 2. The follow up of Cohort 3 is currently in progress. Follow up of Cohort 1 and 2 provide a view of five years in the lives of drug abusers, an unusual perspective into their criminal, treatment and social activities from the time they came in contact with a DARP participating treatment program, to the time they were interviewed at follow up one-half decade later.

The following Tables present a brief overview of the data from clients in methadone maintenance treatment programs in a limited number of cities during the years 1969-1972. These data reflect a sample which may not be representative of the past drug abusers or the present drug users, either in treatment, in jail, expired, or on the streets. This, however, is the data which we do have, and which presents an important historical perspective and record of the effects, or lack thereof, of Federally funded treatment programs.

Cohort 1 had 4,449 methadone maintenance clients; Cohort 2 had 4,086 methadone maintenance clients. The following data was collected from 1,477 of these clients. Seventy-eight percent of this sample are men. Of the men, 38 percent are Black, 33 percent are White, 16 percent are Mexican-American and 13 percent are Puerto Rican. Of the women, 74 percent are Black, and 26 percent are White. There were insufficient numbers in the original cohorts of Mexican-American and Puerto Rican women to draw a statistically meaningful and representative sample for comparative analysis. Table 1 provides the baseline performance measurements for these clients at the time they entered treatment. These are lifetime or "ever" figures. The median age at the time these clients entered treatment was 26. Eighty-seven percent had been arrested; 36 percent had been arrested at least five times, 73 percent had spent at least some time in jail, and the median age for the first arrest was 16. Fifty-one percent of the clients had at least one prior treatment experience, with 10 percent of the clients having more than three treatment experiences. The median age of first daily use of heroin is 19. Fifty-four percent were unemployed for the entire year prior to entering treatment. This group of clients not only has difficulty with drugs, but also with the criminal justice system and with being a productive member of the community.

Table 2 provides performance measurements for the three years after the clients have left the DARP treatment. This data is prevalence data. It indicates that an event occurred; it does not indicate the severity or duration of the event. This contrasts with Table 3 which provides a view of performance in a limited two-month period immediately prior to the follow up interview. This two-month period data is point prevalence, and more nearly represents the behavior of the individuals at a specific point in time. The difference between these two data sources also reflects the periodicity or recurrent chronicity of the activities that are reflected in the performance measurements. If the level of performance were not recurrent, then the three-year level would be nearly reflected in the two-month period (essentially at or beyond the end of the three year post-treatment period). The significant differences reflect the significant variations of client behavior during their post-treatment years.

There are significant differences in pretreatment and post-treatment performance. Table 1 indicates the performance measures for the two months pretreatment, and this may be compared with Table 3, which indicates the performance measures for the two months immediately prior to the follow up interview. The follow up interview is approximately four years after admission to treatment. Admittedly, other life events have occurred since the client's admission to treatment. Nearly 60 percent of the clients have had at least one additional treatment experience, nearly 40 percent of the clients have spent some time incarcerated, and 43 percent of the clients have had at least one period of time during which they were using heroin on a daily basis.

In the pretreatment two-month period, 87 percent of the clients were using opioids on a daily basis. (It should be noted that though it is required that all clients entering methadone maintenance treatment programs need to have a positive history of using opiates, there are some clients that enter methadone maintenance programs from detoxification programs, other treatment programs, (jail, hospital, or other sheltered and protected environments); 12 percent were consuming more than 8 ounces of 80 proof liquor equivalents (half pint) daily; 62 percent were unemployed and 38 percent had illegal activities as their major source of support, only 51 percent of the clients had no illegal support. This contrasts with the post-treatment period, at which time 8 percent of the clients are reporting daily opioid use; 17 percent were consuming more than 2 ounces of 80 proof liquor equivalents daily; 48 percent were unemployed and 18 percent had any illegal activity. In addition, at the time of follow up, 38 percent of the clients were receiving treatment for drug related difficulties, and 13 percent were in jail.

The performance data from the three year period after discharge reflects the recurrent nature of the drug abuse problem. At some point during those three years, 43 percent of the clients used opiates for a period of time. Seventy-six percent of the clients held some form of employment; when one converts the percent months employed for persons employed to person-years, then the full time employed equivalent indicates that subsequent to treatment nearly 50 percent (49.4 percent) of the clients are full time employed at any point in time. A similar technique may be applied to full time equivalents in jail at any point in time--11 percent, or full time equivalents in treatment at any point in time--31 percent. The differences between these values and those found at the time of follow up interview represent trend changes and long-range effects of treatment. After the DARP treatment, and with other treatments, employment would be expected to increase, criminal behavior decrease and drug use decrease. In fact, only the latter--a continued decrease in drug use--can be documented, during the three-year post-treatment period. This reflects the clinical judgment that though drug use may be altered and other changes in the client's life occur, improvement in the more complex social areas of employment and criminal behavior require additional post-treatment intervention.

TABLE 1

PRETREATMENT PERFORMANCE MEASUREMENTS OF CLIENTS ENTERING METHADONE MAINTENANCE TREATMENT PROGRAMS 1969 -1972

	TWO MONTH PERIOD PRETREATMENT (percent of sample of 1477)
DRUG USE	
Daily Opioids	87
Less than Daily Opioids	7
No use or missing data	6

It should be noted that though it is required that all clients entering methadone maintenance treatment programs need to have a positive history of using opiates, there are some clients that enter methadone maintenance programs from detoxification programs, other treatment programs, jail, hospital or other sheltered and protected enviornments.

ALCOHOL USE (in 80-proof liquor equivalents)	
None or infrequent	69
0.1 - 4.0 oz. per day	11
4.1 - 8.0 oz. per day	8
Over 8.0 oz. per day	12
EMPLOYMENT (days)	
None	62
1 - 15 days	6
16 - 30 days	8
Over 30 days	24
MAJOR SOURCE OF SUPPORT	
Legitimate job	28
Public assistance	12
Spouse	4
Family	13
Illegal	38
Other	5
ANY ILLEGAL SUPPORT	
Yes	49
No	51

TABLE 2

POST-TREATMENT PERFORMANCE MEASUREMENTS OF CLIENTS ENTERING METHADONE MAINTENANCE TREATMENT PROGRAMS 1969 - 1972

THREE YEAR PERIOD AFTER DISCHARGE

	(percent of sample of 1477)
DRUG USE	
Daily opioids	43
Less than Daily Opioids	63
No use or missing data	37
ALCOHOL USE	
Over 8 oz. per day of 80-proof alcohol	21
ANY EMPLOYMENT	
YES	76
NO	24
Percent months employed for persons employed............65	
ANY TIME IN JAIL	
YES	39
NO	61
Percent months jailed for persons jailed.............28	
ANY DRUG TREATMENT	
YES	56
NO	44
Percent months in treatment for persons in treatment........55	

TABLE 3

POST-TREATMENT PERFORMANCE MEASUREMENTS OF CLIENTS ENTERING METHADONE MAINTENANCE TREATMENT PROGRAMS 1969 - 1972

TWO MONTH PERIOD AT FOLLOWUP
(an average of four years after admission to treatment)

	(percent of sample of 1477)
DRUG USE	
Daily opioids	8
Less than Daily Opioids	28
No use or missing data	72
ALCOHOL USE	
Over 8 oz. per day of 80-proof alcohol	17
ANY EMPLOYMENT	
YES	52
NO	48
EITHER BOOKED OR JAILED	21
Jailed	13
Booked on Charges	13
ANY ILLEGAL SUPPORT	
YES	18
NO	82
IN DRUG TREATMENT	
YES	38
NO	62

What kind of record-keeping is required?

Section 1402.12 of the Federal Funding Criteria, which is a part of the scope of work of the SWSC, requires that "Each program shall establish a patient record system to document and monitor patient care. This system shall comply with all Federal and State reporting requirements. All records shall be kept confidential in accordance with the applicable regulations . . ." The SWSC requires that programs maintain financial records of income (e.g., Federal income, contract related income, match) and expenditures. Such records are subject to audit. The specifics are contained in both the General and Special Provisions of the SWSC.

The SWSC requires that the contractor furnish client related data in accordance with the requirements of the current Client Oriented Data Acquisition Process (CODAP). However, this requirement is a reporting and not a record-keeping requirement.

How do you discover ineffective or inefficient programs?

Ineffective and inefficient programs can be discovered in a number of ways. They can be identified through SSA or NIDA monitoring site-visits, through PMRs, through quarterly reviews, or through self-identification by either the program or the SSA.

Do you defund these?

While every effort is made to provide assistance to programs, under the provisions of the SWSC, the prime contractor has the authority to modify or terminate any subcontract. Prime contractors have exercised this authority as necessary.

Has NIDA developed drug abuse treatment standards to assure uniform quality drug abuse care? If there are no uniform standards, how can you evaluate the effectiveness of programs?

In addressing the issue of quality of care, we in the Federal government must be fully cognizant of what we can achieve, and what is realistically beyond our scope, in order that our activities are properly oriented within an overall framework. This NIDA has done, and one of our major roles has been the provision of leadership and guidance in the establishment of treatment standards for drug treatment services. NIDA assisted SAODAP in the development and promulgation of the Federal Funding Criteria. The Federal Funding Criteria established uniform minimum treatment standards for drug treatment programs funded under Section 410 of P.L. 92-255. We must point out, however, that these standards cannot, in themselves, ensure that quality treatment services are delivered. What they can ensure is that a program's design and operation have been established within a framework such that quality treatment services can be delivered.

NIDA recognizes that even the most tightly monitored program, which meets the most exacting of accreditation standards, may not provide quality care when the door is closed and the client and the counselor are face-to-face. The ways to influence this critically important interaction are subtle and complicated with many entities entering into the picture (e.g., NIDA, the Food and Drug Administration, Single State Agencies, the Joint Commission on Accreditation of Hospitals, the American Medical Association, etc.). We at NIDA are also well aware that overregulation is unlikely to achieve a beneficial purpose. The addition of regulations and paperwork cannot guarantee quality in this area where sound clinical judgment and dedicated staff are key factors.

In addition to the Federal Funding Criteria, NIDA has also made a considerable and continuing investment in the establishment of guidelines relative to the management of drug treatment programs and their monitoring (e.g., the Statewide Services Contract Policy and Practice Manual, and the Statewide Services Contract Program Review Manual). We believe that there is a higher likelihood that quality care will be delivered in a well-managed program than in a program which is not well managed. NIDA will continue to be active in the establishment of guidelines and monitoring indicators which thus relate, though not necessarily directly, to quality care.

NIDA will continue to encourage SSAs to develop their own treatment standards. If these State standards substantially meet to exceed our Federal Funding Criteria, they can be accepted in lieu of the Federal standards. A staff member of our DCA will continue to be available for the provision of consultation and technical assistance to SSAs in the development of their State treatment standards.

The Institute will continue to encourage our funded treatment programs to participate in the Joint Commission on the Accreditation of Hospitals (JCAH) quality improvement/accreditation program. The JCAH accreditation standards for drug abuse treatment and rehabilitation programs represent maximally achievable standards for the field at this time. They were developed by JCAH under a NIDA contract.

NIDA will also continue to participate with the Food and Drug Administration in the development of methadone regulations and treatment standards. Through the Interagency Methadone Policy Review Board, our Institute will continue to be involved in reviewing, recommending, establishing and implementing treatment standards designed to enable the provision of quality patient care in the treatment of narcotic addiction.

NIDA RURAL INITIATIVES

The following report is divided into three parts:

- Data on rural/urban drug use
- Rural service delivery
- Current and future rural NIDA studies

Rural is defined as population of 25,000 or less, not located in a Standard Metropolitan Statistical Area (SMSA).

Data on Rural/Urban Drug Use

NIDA has no national statistical information on the number of rural drug users. A pending contract on the National Survey of Illicit Drug Use (cited later) will draw a sample of 2,000 persons in rural households to yield information on the nature and extent of drug usage. Information on clients in federally funded rural treatment programs is available through the Client Oriented Data Acquisition Process (CODAP).

In terms of the nature of drug use, there appear to be substantial differences between the drugs reportedly used by clients admitted to rural programs and clients admitted to urban programs. Heroin is the primary drug of abuse in admissions to treatment programs in urban areas, while marihuana is the primary drug of abuse in rural treatment programs. CODAP data from 1975 showed 65.7 percent of the urban treatment population admitted for opiate abuse as compared to 8.1 percent of the rural population. 30.7 percent of the rural treatment population were involved in marihuana abuse compared to 10.7 percent of the urban treatment population. 16.6 percent of the rural population admissions to treatment involved sedative/hypnotics compared to 6.9 percent of the urban population. Amphetamine abuse accounted for 15.8 percent of rural admissions compared to 5.8 percent of urban admissions.

CODAP data from 1977 (which examined only outpatient drug-free programs) showed that 16.9 percent of the rural admissions reported the use of amphetamines as their primary drug of abuse, and only 12 percent of the urban population reported the same. Rural programs reported 6.9 percent of their clients using tranquilizers as the primary drug compared to 3.7 percent of the urban clients. In terms of opiates (excluding heroin), 6.2 percent of the rural admissions reported them as primary drugs of abuse compared to 4.3 percent in urban areas. There are 7.4 percent of the rural admissions using sedatives as primary drugs compared to 3.5 percent in urban areas. Marihuana is the primary drug of abuse in rural areas (27.1 percent rural vs. 13.2 percent urban) and heroin is the primary drug in urban areas (35.2 percent urban vs. 6.3 percent rural).

Data appears to indicate a change in the age of rural admissions in the past two years. The number of admissions on the younger end of the age scale has declined from 62.2 percent for those persons 20 or less in the 1975 data to 48.6 percent in that same category in 1977. Although the percent of those in ages 21-25 have remained constant, there has been an increase in the 26-30 category from 8.7 percent (1975) to 12.8 percent (1977), and an even more substantial jump in the 31 and over age category from 6.5 percent (1975) to 15.0 percent (1977). The data indicate that a little over one-fourth of the rural treatment population is over 26 years of age at admission. No reason for the shift in age can be given at this time.

1977 CODAP data indicate that 88 percent of the rural treatment population is Caucasian compared to 62 percent of the urban treatment population. 37.4 percent of the rural treatment population is female compared to 27 percent of the urban population. There appear to be no differences between rural and urban treatment populations in terms of the number of times arrested and the length of time in treatment.

1975 CODAP data indicates that 88 percent of the admissions in rural programs were voluntary compared to 81.7 percent in urban programs. In addition, 78.1 percent of rural admissions had no prior treatment experience compared to 45.9 percent of urban programs.

The rural/urban comparison would not be meaningful without the examination of data regarding frequency of use. Although there is a rural/urban difference in type of drug used, the differences regarding the continuum of light/heavy use are important. A comparison was made between rural and urban clients concerning their frequency of drug use at admission (1977 CODAP data). Comparisons were made between urban and rural drug abuse clients using chi-square tests only on the heavier usage which was from two to three times a week and over. There were significant differences in frequency of use at admissions between rural and urban clients in the use of opiates (not including heroin), tranquilizers, amphetamines and hallucinogens. There was more frequent usage of these drugs in the rural treatment population than in the urban population. There were no significant differences in rural and urban clients in the frequency of use of cocaine, over-the-counter drugs, sedatives, marihuana, barbiturates, or heroin. This indicates that the frequency of heavy use among both the rural and urban clients was similar.

Rural clients' needs and the exigencies of the rural environment dictate a different approach to service delivery than the approach used with urban programs. Most of the rural programs are small. In a study of 59 rural drug treatment programs, the majority had fewer than 10 paid staff members. Because of a small local tax base, there is little economic contribution from the local government. There also exists a variety of program structures and operations such as satellite facilities, umbrella organizations and affiliation with community mental health centers. 26 (46 percent) of the 57 programs for which data were available operated more than one facility. Twenty five (42 percent) of 59 programs studied were affiliated with community mental health centers.

Many programs have complained about transportation problems and distances in rural areas. Many programs reported difficulty in being accepted by the community. Other problems cited were funding, lack of experienced staff, poor salaries, lack of career advancement, and poor management. A major complaint from rural programs is that staff members often spend a great deal of time in travel between satellite facilities, outreach, and information/education activities (e.g., student, parent, service club lectures and discussions). The boundaries between treatment and prevention believed to exist in urban areas are seen as inappropriate in rural settings. Rural staff reported that maintaining both independent and satellite facilities for a relatively low volume of clients - coupled with added travel and casefinding expenses incurred in covering large catchment areas - considerably increased costs. Programs are funded indirectly by NIDA through the States. Only costs incurred for actual treatment are reimbursed to the program. Rural programs have complained that costs incurred in functions such as staff travel and outreach are not included as part of treatment costs.

Current and Future NIDA Rural Studies

1. Comparison of rural/urban 1977 CODAP data. Currently in draft. Awaiting CODAP data from last quarter of 1977 so that the entire year of 1977 can be examined.

2. Prevalence of Mental Health Conditions Among Migrant Health Centers - joint project with National Institute on Alcohol Abuse and Alcoholism and the Bureau of Community Health Services. Study examined records at nine migrant health centers to determine prevalence of drug, alcohol, and mental health problems. It was found that drug abuse is not a significant problem among the people who use migrant health centers.

3. Thee Door Substance Abuse Project, Orlando, Florida. Project ends August 1978. Study compares drug treatment among farm and non-farm workers. In addition, a survey of 800 migrants and seasonal farm workers is being made to determine drug usage among that population.

4. National Survey of Illicit Drug Use. This is a national survey of non-medical drug usage which has been conducted bi-annually since 1975. In the past, this survey was focused largely in metropolitan areas. This year, as a special part of the national

survey, a sample will be drawn of 2,000 persons, age 12 and over, in households located in rural areas. This will allow NIDA to examine rural data alone, and will also allow comparisons to the urban sample of 3,000 subjects. This will be NIDA's first study on a national level of rural drug usage.

5. NIDA staff will be working with the rural/suburban task force of the National Drug Abuse Conference around rural issues.

6. NIDA staff participate in the NIMH rural work group, composed of staff from NIMH, NIAAA, and the Department of Agriculture. The group is examining the idea of a research and development center located in a rural area.

7. June 1977 - National Association of State Drug Abuse Program Coordinators Conference - Dr. Barry Brown, Chief, Services Research Branch, Division of Resource Development, NIDA, spoke on NIDA rural reports.

8. April 1978 - National Drug Abuse Conference - Dr. Rebecca Ashery, Services Research Branch, reported on rural/urban 1977 data to the Rural panel (see attached draft presentation).

PUBLISHED REPORTS

HEW Services Research Report "An Investigation of Selected Rural Drug Abuse Programs" - March 1977 (attached).

This study reported on both the data derived from CODAP and the anecdotal information contained in the rural survey. It suggests that the rural drug abuse client is different from his/her urban counterpart. The finding that the rural abuser is comparatively young has a number of implications for both treatment and policy. For example, when client age is coupled with the nature of the drugs abused, it suggests that educational, recreational and psychological resources will be primary in developing a rural client's treatment plan, rather than the vocational, legal and social welfare referrals appropriate for the majority of urban clients.

The finding that more than one-third of rural clients are 17 years or younger compared to less than seven percent of urban clients suggests that intervention with clients' families may be an important treatment technique for rural programs. Furthermore, increased consideration may need to be given to rural transportation problems since they can affect both clients and others significant to the rehabilitation process.

Rural treatment staff believe that they bear major responsibility for educating their community about the drug abuse problem. The boundaries between treatment and prevention, which may be observed in urban centers, are seen as inappropriate in the rural setting.

HEW Services Research Report "Nonurban Drug Abuse Programs: A Descriptive Study" - January 1978 (attached). This is a descriptive study of 59 rural drug abuse programs and suggests that the nonurban drug abuse treatment client is different from his/her urban counterpart. The clients of nonurban treatment programs are typically young, with marihuana, amphetamine, and alcohol problems predominating. (Other findings are incorporated in the narrative.) In addition, brief descriptions of innovative solutions that have been used by rural programs to solve program problems are presented.

STRATEGIES

Rural issues NIDA is interested in addressing in the future:

Projects focusing on the development of new service delivery models in rural areas.

An in-depth marihuana study focusing on a) extent of marihuana use in rural areas; b) the attitudes of the rural community regarding marihuana usage; c) meaning of marihuana use as an indicator of family/mental health problems; and d) pathways to treatment.

Grants addressing programmatic issues such as outreach, service linkages to other programs, transportation, formal and informal support systems.

Survey of drug use among rural racial and ethnic minorities including: a) nature of problem; b) whether rural minority groups are currently being serviced by local drug programs; c) to what extent are problems of rural minorities similar or different than those of minorities in urban areas; and d) unique outreach and/or treatment techniques needed to address problems of rural minorities.

The question of whether rural people in need of treatment migrate to urban centers for treatment.

The Services Research Branch is encouraging potential grantees to address these issues on a national, state, or regional level.

NATIONAL INSTITUTE ON DRUG ABUSE

DIVISION OF RESEARCH

FIVE-YEAR FORWARD PLAN, FISCAL YEARS 1980-84

The Division of Research will continue, over the next five years, its program of knowledge development and utilization concerned with the basic sociological, behavioral, and biomedical mechanisms underlying drug abuse with the eventual goal of successfully preventing and treating this public health problem. The research program is divided into two components; intramural and extramural.

A major goal of the intramural program is the relocation of the Addiction Research Center (ARC). The ARC's Clinical Research Program has been unable to function since the Bureau of Prison's decision not to allow prisoners to participate in biomedical research. Given the potential economic, social, and health consequences of our continued inability to assess the abuse liability of new compounds and to develop new treatment drugs for drug abuse, NIDA feels that it is essential to re-establish the ARC at a location where clinical research subjects can be recruited. Pending the approval of the Secretary, DHEW, we plan to move the ARC's clinical and basic research programs beginning in fiscal year 1980. The cost of the proposed move is 4.5 million dollars.

The major goal of the extramural research program is the development of the knowledge that will enable us to prevent and treat drug abuse. Research is a continuous process and we will maintain support for many of our currently productive programs which are providing increased understanding of the drug abuse process. Among these are areas described in past Forward Plans such as further research on (1) the clinical significance of the endogenous morphine-like substances, (2) drugs and driving performance, (3) the epidemiology of drug abuse, (4) genetic and developmental effects of abused drugs, (5) inhalant abuse, (6) the effects of social policy of drug abuse, (7) women and drug abuse, (8) substance abuse, (9) human behavioral pharmacology, (10) crime and drugs, and (11) personality predictors of drug abuse. In addition to the foregoing, there are a number of programs and initiatives of especial importance which will be increasingly emphasized.

RESEARCH ON TREATMENT

During the past few years the most important treatment program has been the development of LAAM, an alternative to methadone in the treatment of heroin addiction.

In fiscal year 1980, LAAM will continue to be developed as a standard therapeutic drug. This drug is presently undergoing its final phases of clinical testing. We anticipate further clinical testing in 1980 to answer particular questions raised by the Food and Drug Administration concerning the planned submission of a New Drug Application for LAAM. Large-scale clinical testing of LAAM in women should also begin in 1980. The final carcinogenicity testing of LAAM will also be concluded in 1980. The estimated cost of this program is $1.8 million in 1980.

There has also been an extensive program for the development of naltrexone, a narcotic antagonist in the treatment of heroin addiction. In 1980 the large-scale clinical tests of naltrexone should be continued. Pending the results of toxicity studies, it is anticipated that the clinical testing of a long-term depot preparation for naltrexone will also be initiated. The cost of this program will be $1.2 million in 1980.

NIDA is beginning to develop a new drug which may have significant potential as a treatment agent. This drug, buprenorphine, is a partial agonist of the morphine type with a long duration of action. In practical therapeutic terms, these characteristics of buprenorphine indicate that this compound has the potential for producing a psychic effect that should be acceptable to addicts in treatment. It will require a dose schedule less frequent than methadone and possibly as infrequent as with LAAM. Buprenorphine appears to be significantly less toxic than other treatment drugs and may even be non-toxic.

Further, buprenorphine appears to be capable of blocking the toxic, euphorogenic, and physical dependence producing effects of self-administered heroin or other narcotics. It will produce cross-tolerance like methadone, but will also act as a competitive antagonist like naltrexone.

Finally, buprenorphine appears to produce little if any physical dependence, and maintenance therepy could therefore easily be terminated. In 1980 the results of initial limited scale Phase II clinical testing of buprenorphine will be completed and a decision made as to whether to proceed with the continued development of this drug. The estimated cost of this program in 1980 is $1.4 million.

NIDA is also interested in developing a comprehensive and practical approach to the treatment of the heroin dependent person and drug abusers that is based on theoretically sound knowledge of the psychiatric state of dependent persons and on the psychodynamics of drug abuse and psychological dependence. Research in this area has already shown that many addicts suffer from depression and that treatment with anti-depressants is of considerable value in treating drug addiction in these patients. These studies will be continued and expanded during the next five years. NIDA supported research will seek to assess the psychiatric status of addicts in and out of treatment and will also attempt to assess the impact of various types of psychotherapeis on treatment outcomes. The additional cost of this program in 1980 will be $0.3 million.

There is also a need for a study of the context of treatment and of the characteristics of treaters. Presently, there is insufficient research being performed on types of treaters and of their effect on the treatment process. NIDA plans to develop a methodology to measure the treatment process, clinical milieu, and various characteristics of therapy. This is an area in which cooperation with the alcohol research field would be especially important because it takes a particular type of dedicated professional, in both fields, to stay with treatment of what must seem, in both cases, an almost incorrigible disease. A model for such a study was done years ago in studying psychiatrists in public and private institutions (the "burnout snydrome" among treaters should also be explored). This kind of program will have to be done on a broad basis to capture the varieties of existing programs and their staffs. The estimated cost of this program is $0.4 million.

Finally there is currently a consensus that there is a deficiency in the numbers and sophistication of clinical researchers in the field of drug abuse treatment. An important initiative aimed at training new and more able clinical researchers is of the highest priority. As currently conceptualized, this would involve the use of training funds to develop training instruments in the three critical phases of drug abuse treatment research.

The most fundamental need of all clinical researchers in an understanding of experimental design appropriate to drug abuse treatment research. This can be best achieved by three interrelated activities. The first would involve the writing of a handbook on experimental design focusing on such areas as, flexible vs. fixed dose studies, open vs. single vs. double-blind studies, single subjects designs involving baseline and post-treatment measures, cooperative studies designs, etc. A second would be training seminars held regularly and perhaps regionally in which discussion of experimental designs appropriate to specific questions could be reviewed. Finally, training could be achieved by direct technical assistance in the planning and implementation of research.

A second area where clinical researchers need training is in the structuring and maintenance of a research clinic. A research clinic is a unique institution which sits between the treatment and research communities and is often looked upon with suspicion from both sides. Specific problems encountered in establishing and maintaining a research clinic revolve around the selection of clinic staff who are supportive of the concept of evaluating treatment. Another issue is staff participation in research, including open discussions of protocol, design, changes in protocol, exceptions to the protocol made for individual patients, inclusion and exclusion of certain individuals from the study, etc.

Still another area where training is necessary is that of the relationship of the research clinic with the treatment community. The research clinic depends on the treatment community for its source of patients and for the continuity of care of its patients. Separate issues, such as the funding of research clinics, would also be undertaken.

A final area in which clinical researchers need training involves various methodological procedures. This concerns the use of data collection instruments including staffing requirements for data collection, mechanisms for checking on the quality of data collection, data processing, data analysis, etc.

Based on the assumption that many, if not most, treatment facilities, especially those associated with research institutions such as universities, have the basic attitudes necessary for the development of research clinics, it would be helpful to provide training and thereby create a cadre of clinical researchers with the knowledge of the basic skills required for the design of studies, for the administration of research clinics, and for the collection and processing of data.

This training program can be implemented through pre- and post-doctoral fellowships and by the use of Research Career Development Awards. The Division of Research estimates that $0.3 million will be used for career awards to clinical researchers in FY 1980.

CIGARETTE SMOKING

Cigarette smoking is the nation's most widespread, costly, and dangerous habit. It involves 1/3 of the national population and leads to 30[illegible],000 deaths per year. NIDA has recently initiated a program in cigarette smoking behavior that will continue to further our understanding of the etiology and basic mechanisms of nicotine dependence and withdrawal and to increase our effectiveness in the treatment of this public health problem. Much research needs to be done and investigator initiated research is being stimulated. We plan to spend an additional $1.0 million in the following areas.

Specifically, further research is planned on the biomedical, psychological and social factors which predispose many, but not all, individuals to experiment with cigarette smoking. This program will include investigations on (a) possible genetic factors influending an individual's response to nicotine, (b) the role of hypothesized nicotine receptors in predisposing a person to nicotine dependence, (c) personality variables causally related to cigarette smoking, (d) the role that social or ethnic class and peer groups play in the initiation of smoking behavior, and (e) behavioral and conditioning factors which influence the acquisition, maintenance, and extinction of tobacco smoking.

Little is known about the basic physiological and psychological effects of nicotine dependence and withdrawal. Further research is planned concerning (a) the sites of action of nicotine in the central nervous system, (b) the mechanism by which nicotine exerts its reinforcing effects, (c) the structures and mechanism involved in the abstinence syndrome resulting from cessation of ciagette smoking, (d) the existence of an endogenous nicotine-like substance in the brain, and (e) the possible existence or creation of a nicotine antagonist.

Finally, there is some indication that it may be more difficult to stop smoking than to stop the self-administration of opiates. Research on new techniques to help individuals to reduce or eliminate tobacco-smoking behavior will be developed. These include approaches which emphasize (a) the application of behavior modification techniques, (b) the development of educational progress to change public attitudes toward smoking, (c) the development of pharmacological therapies which replace cigarette smoking with other less harmful substances.

EXPANSION OF BASIC RESEARCH

NIDA plans to expand its basic research programs. Over the past few years a relatively flat budget, inflation, and new obligations such as the initiation of a tobacco smoking program have seriously affected the basic research program. Many of our leading laboratories are in need of new and replacement equipment. The estimated increase in this area is $2.0 million and it will focus on the following research.

Physical Predisposition to Drug Abuse

A body of information is beginning to form which clearly implicates certain biomedical factors as predisposing individuals to drug and substance abuse. Based on these findings, some of which are indicated below, NIDA is now able to seriously consider mounting a major extramural research effort concerned with these physiological factors.

For example, recent studies have indicated that individuals from normal college student populations who have low activity levels of an enzyme (monoamine oxidase, MAO) that affects brain activity, score high on personality measures such as the sensation seeking scale (SSS). Moreover, high scores on this scale have been associated with increased marihuana, hashish, amphetamine and LSD use. Individual preferences for stimulants or polydrug abuse have also been associated with high sensation-seeking scales. During the past year NIDA researchers have shown that activity levels of MAO in male marihuana smokers was significantly lower than in a comparable group of non-marihuana smokers and that the level of current marihuana use was inversely correlated with MAO activity. It would appear that these enzyme activity levels may provide a reliable index of an individual's proclivity to abuse drugs given access to the drugs. We plan to further investigate this problem in the coming year and to inlude tests for MAO activity levels in our ongoing longitudinal marihuana study so that we can determine, in the future, how many individuals with low MAO levels went on to abuse drugs as compared to those with normal MAO activity.

Other examples of biomedical factors predictive for drug abuse include the possible role of low endorphins, depressive states, and psychopathy in the etiology of narcotic addiction. A number of additional biomedical factors that should be studied for their role in drug abuse include: (a) increased levels of endogenous antagonists, which may be the functional equivalent of low endorphin, (b) perinatal exposure to drugs. Once exposed to or addicted to narcotics, there appears to be some type of biological memory, and re-addiction may occur with greater ease; (c) there appears to be a naturally occurring benzodiazapine-like receptor and presumably a naturally occurring benzodiazapine-like chemical. The abuse or need for tranquilizers may be caused by a deficiency in this system.

Neuroscientific Basis of Drug Abuse

There is a need for further expansion of studies concerned with the basic neural mechanisms underlying drug abuse. Of particular interest is the neurobiology of euphoria and dysphoria, of the reinforcing properties of drugs, and of compulsive and habitual behaviors.

In addition, a variety of drugs have been studied with respect to their actions on neuroendocrine function and among these the opiates and marihuana have received the most attention. In general, it can be concluded that all the drugs studied produce effects on the neuroendocrine system.

The opiates and marihuana generally depress luteinizing hormone (LH), a chemical that stimulates ovulation and estrogen release, and testosterone levels which is manifest as disturbances in sexual function commonly reported by users of these drugs. The actions on the other hormones are more variable, they do not produce a readily apparent clinical symptomatology. The effects produced by the drugs on these other hormones may be reflected in more subtle changes, such as altered states of mood and behavior.

Continued use of some drugs markedly disrupts the normal function of the parts of the brain concerned with hormonal release and emotional states. Some of this dysfunction is directly coorelated with the altered chemicals in the brain. The importance of studying the effects of drugs upon the neuroendocrine system stems from recent neuroendocrine correlations between pituitary function and certain brain chemical activity. Studies along these lines may provide further information relative to the effects of drugs of abuse upon these brain chemicals.

This information would enable us to gain insight into new therapies for drug addiction. It may be possible, for example, to modify the withdrawal syndrome by administration of transmitter precursors and hormones.

Effects of Social Conditions on Drug Abuse

It is a commonly held belief that poverty and unemployment affect drug abuse. Research is planned to investigate the possible role of these variables in drug abuse, and, if they prove to be important, an attempt will be made to understand the mechanisms by which these social conditions exert their influence. Such studies might concentrate on how environmental factors interact with psychobiological factors in affecting drug abuse behavior.

RESEARCH ON PREVENTION OF DRUG ABUSE

NIDA plans to expand studies on the prevention of drug and substance abuse. We intend to add an additional $3.0 million for research. Part of this program will invole the establishment of Program Projects concerned with prevention and with preventive medicine.

The goal of the Prevention Program Projects would be to reduce the incidence and prevalence of drug abuse and cigarette smoking behavior. In the past, this effort was concentrated mainly on social scientific approaches. The present program would seek to identify the etiological factors, social, behavioral, and biomedical, that lead to drug abuse and cigarette smoking and would develop techniques for interfering in that process. For example, should research show that individuals with low endorphins are "at risk" of becoming drug abusers, the Prevention Program Projects might attempt to devise research studies to test the value and feasibility of initiating a naltrexone program with them. Such a Prevention Program might also study the dynamics of small social group interactions in a rigorous substantive effort to attempt to understand what actually is the power of peer pressure and how it may be controlled.

A recent emphasis in the national research program derives from awareness that the etiology of much drug abuse relates to general patterns of excessive and obsessive behavior. These patterns of habitual behaviors are extraordinarily difficult to eradicate. These types of behavior, which may also be referred to as disorders of self-control, include the use of licit and illicit drugs, alcohol, and tobacco, general dietary excess, and possibly certain aberrant behaviors such as gambling and child abuse. Taken together, these behavior patterns can conservatively be considered as leading contributors to the nation's overall health problems and are the group which would appear to be the most amenable to prevention and alleviation through understanding the mechanisms of self-control.

NIDA also intends, as part of its prevention program, to fund Program Projects in preventive medicine. The function of these Program Projects would be to bring together an interdisciplinary group of scientists whose major goal would be to investigate and develop techniques, social, behavioral, educational and biomedical, which will enable individuals to reduce or eliminate maladaptive behaviors such as drug and substance abuse. For example, research on animals suggests that certain forms of compulsive behavior may result from a dysfunctional frontal lobe. Further study may show that a treatment approach can be based on some type of chemotherapy that selectively affects this part of the brain. On the other hand, learned behavior patterns no doubt play a role in other forms of substance abuse and appropriate behavioral approaches could be developed to treat this type of problem. To restate, the function of the Preventive Medicine Program Projects would be to develop techniques, not necessarily behavioral ones, to change behaviors such as smoking, that produce medical problems. The prevention research program will also emphasize studies in the following areas:

Gateway Drug Use

This initiative would seek to more fully identify conditions of acquisition of gateway drug use. This research effort would be primarily focused on individuals immediately at risk of experimentation with gateway drugs, those 10-13 years of age, for it is with this group that we feel progress can be made in interfering with the variables leading to drug abuse. This program plans to investigate the role of the community and peer pressure in early drug experimentation, the possible "adaptive" role of drug-using and smoking in this age group, and the impact of parental smoking and drug-taking.

Evaluation of Media Techniques

Another area of research involves the use of media techniques in preventing drug abuse with a special focus on those in a high-risk category, ages 8-20. The ultimate goal of this initiative will be to determine whether selected media messages on drug-using behavior of a selected population can have positive results. We would eventually draw upon the experience of market research and media design in launching the first comprehensive attempt to assess the impact of specific media intervention wherein all of the major elements of the design would be essentially controlled. However, before this can be attempted it must be determined, on a smaller scale, what mass media programs and messages are appropriate for the prevention of smoking and drug abuse in specific populations. Some of the planned studies are as follows.

1. What procedures can enhance the likelihood of a subject's exposure to media-borne messages?
2. Is there a critical number of exposures which the target group must experience before the message begins to "sink in"?
3. What kinds of messages are particularly appropriate to various age and ethnic groups, and what is the impact of the context in which the message is delivered (with parents, with friends, alone at home)?

4. Is a media campaign alone likely to have an impact on drug abuse behavior or will cost effectiveness be increased by adding other components such as films, games, health education courses?

Finally, an effort will be made to extend the small-scale laboratory studies described above to small-scale limited field studies such as in high schools.

Study of Invulnerables

An interesting approach to the prevention of drug abuse with implications for other areas of mental health involves the study of so-called invulnerables. We are all aware of the ancedotal tales of the poor child, in destitute surroundings, with uneducated parents, who, in spite of these handicaps, becomes a success in one field or another. What we are interested in studying is how unusual, relatively speaking, similar success stories are and how the individuals concerned are "protected" from becoming a part of the self-destructive behavior associated with growing up in high risk environments, i.e., what variables are responsible for the fact that some people avoid becoming heroin addicts in the midst of a heroin epidemic.

This research will involve identifying and developing case histories of adults exposed to a high drug abuse risk who proved resistant to becoming drug addicts or alcoholics. By studying a sufficient number of such individuals both psychologically and physiologically, we may be able to isolate the factors responsible for their resistance and apply them to prevention methodologies.

NATURAL HISTORY OF DRUG ABUSE

Another area of renewed interest involves the natural history of drug abuse. We plan to increase our understanding about the various stages of initiation, practice, and final outcomes of drug abuse careers. Such information should prove helpful in evaluating treatment programs and in developing prevention programs. For example, such research might show that there are periods of increased or decreased use in an addict's career. Knowledge about the variables preceding the changes in behavior could be invaluable.

We plan to gather additional information concerned with the factors associated with the onset and cessation of drug abuse behaviors. In other words, what variables are common to those individuals who become drug abusers and what variables are common to those individuals who successfully stop their drug abuse. Such a program will include expanded studies on the experimental analysis of social behavior, the biological changes that occur with age, and the psychobiology of motivation for use among sub-groups. For example, it appears that some people begin to take drugs as a way to get "kicks" while others begin drug experimentation as a means of self-medication. An understanding of these processes would have profound effects on our thinking about drug abuse treatment and prevention.

Finally, the Division of Research plans to expand the study of the natural history of clients in the Federal treatment system through a Treatment Outcome Prospective Study (TOPS). TOPS is a multi-city, multi-modality project which will allow us to longitudinally follow a diverse client population base and to describe the changes that occur with treatment. The study will also generate new hypotheses as to the effectiveness of various treatment modalities.

The estimated cost of these studies on the natural history of drug abuse is $3.0 million.

HAZARDS OF DRUG ABUSE

NIDA plans to expand research on the hazards associated with drug abuse.

Phencyclidine and Phencyclidine-like Drug Abuse

The use of phencyclidine (PCP), known on the street as angel dust and by a score of other names, may be the most rapidly growing pattern of drug abuse in recent years. Because the drug frequently masquerades as other substances, any survey statistics represent a minimal estimate of the extent of the problem. However, between the 1976 and 1977 National Institute on Drug Abuse National Surveys, the number of those between 12 and 17 who were aware that they had used PCP doubled. Among the 18 to 25 year-old group during that same year, use had also increased by nearly 50%. This occurred despite the poor street reputation of the drug, the evidence that it can be life-endangering, and the fact that it can cause a serious schizophrenic-like toxic reaction.

The rapid growth of this serious pattern of drug abuse is alarming. Since little is presently known about the psychological and biological inplications of PCP, it is important that the parameters of risk for both acute and chronic use be understood. Such knowledge may also serve as an effective deterrent to use if it is employed in well-designed prevention programs.

The purpose of this initiative is to stimulate research concerning the basic sociological, psychological, and biomedical aspects of phencyclidine and phencyclidine-like drug abuse as well as to develop effective treatment and prevention methodologies.

More specifically, additional studies are planned on the incidence and prevalence of PCP abuse. The increased use of PCP, in spite of its bad street reputation, offers a unique opportunity to test the hypothesis that the extent to which a drug or substance is abused is primarily determined by relative availability. Research will also be concerned with the patterns of PCP use which should include information concerning what drugs, if any, are usually taken together with PCP.

In the behavioral area, studies will address the issue of the personality characteristics of PCP abusers and their motivation for use. An area of particular importance involves the frequency and significance of adverse behavioral toxicity episodes including criminal activities and aggression. Investigations will also address the significance of the schizophrenic-like toxicity that has been reported following PCP abuse and methods should be developed to provide a differential diagnosis of this PCP induced toxic psychosis as opposed to schizophrenia and other psychotic disorders.

Little is presently known concerning the acute and chronic effects of PCP abuse on psychological and physiological function and performance and on the development of tolerance and dependence. An animal model for PCP abuse should be developed and basic biomedical studies initiated. The interaction effects of PCP with other drugs such as alcohol, marihuana, and barbiturates are of especial interest as are the possible genetic and reproductive effects. Since there appears to be a marked variability in response to PCP, drug-response studies are needed with particular emphasis on individual differences.

The development of methods for the rapid assessment of PCP and PCP-like compounds in body fluids is necessary from the experimental, treatment, and forensic points of view. Methods for detoxification and treatment of abusers will be developed and rigorous research on prevention strategies based on both behavioral and biomedical concepts is planned. The estimated cost of this program is $0.4 million.

Longitudinal Studies of Marihuana

There has been increasing concern on theoretical and clinical grounds that marihuana use may have more serious deleterious effects on an individual when used during late childhood and early adolescence than it does on the young adult, who has been the subject of most marihuana research. Such adverse consequences might be the result of a special vulnerability arising from such factors as endocrinological changes, rapid growth and immature ego development which are characteristic of this age group.

The primary purpose of this initiative is to focus on possible special hazards of marihuana use for those from age 11 to 15 (approximately). Such studies will concentrate on the biological, social, and behavioral consequences of use in this age group. Planned areas of research involve studies on genetic, endocrinological, immunological, and developmental effects in the biomedical area and studies on interpersonal relations, school performance, and psychodynamics in the social and behavioral sciences.

Other types of research that we plan to initiate involve biomedical, clinical, and psychosocial studies focusing on (a) longitudinal studies on specific populations, (b) childhood and adolescence in traditionally using populations, (c) multiple drug use in young user populations in which cannabis is the predominant drug, and (d) users with developmental anomalies in which cannabis use might be expected to exacerbate already existing problems. Prominent emphasis will also be placed on female users since this group of users has been relatively neglected in research to date despite the fact that in younger age groups female use is approaching use with male use. The estimated cost of this research is $0.4 million.

Inhalants

Another area of increased significance involves the abuse of inhalants.

The demonstrated toxic effects of inhalant abuse require that further attention be directed at this problem. Inhalant abuse can result in permanent brain damage and concomitant neurological deficits. The problem is particularly acute among minorities, particularly Mexican-Americans and Indians, and in young age groups.

The purpose of this initiative is to increase knowledge in the following areas so that the extent of the inhalant abuse problem can be understood and an effective treatment and prevention strategy developed. Among abused drugs, the inhalants are essentially unique in the severity and chronic nature of the resulting impairments. Further research is planned on (a) the cognitive, behavioral and other neurological impairments caused by various inhalants (and combinations), especially in human subjects; an important subarea involves the hazards associated with acute heavy as opposed to chronic low exposure; (b) the causes of death in inhalant abuse, i.e., whether because of physiological or behavioral toxicity; (c) the neuropathological changes associated with inhalant abuse.

Mexican Americans and Indians as well as many white youths are involved in inhalant abuse. Blacks seem to be relatively uninvolved with inhalants. Studies will be performed to investigate the socio-cultural, psychological and biological bases of inhalant abuse in these groups. Particular attention will be directed at an understanding of differential use patterns. Factors to be considered will include peer pressure, availability, specific effects, membrane permeability, and antigen profiles.

The mechanism by which inhalants exert their addictive and reinforcing processes is unknown. Techniques have to be developed which enable us to study these effects in the laboratory. Further studies are planned which will identify the site of action of various inhalants, as well as the physiological changes occurring with the development of tolerance and during withdrawal. Possible pharmacotherapies can be developed to combat specific withdrawal syndromes and further experimentation in this area is encouraged.
The estimated cost of this research is $0.4 million.

RESEARCH MANAGEMENT

A final major goal during the planning period 1980-84 will be an increased emphasis on research management and utilization. Monitoring of NIDA research grants and contracts takes several forms. Staff members are assigned to individual grants and contracts to ensure that the project specifications are met. The calibre of this monitoring, however, depends on site visits and sufficient staff for evaluation to be more than perfunctory. Travel and position ceilings have imposed severe limits on this function and, hopefully, this problem can be rectified.

A second form of monitoring is accomplished by selecting individual programs for periodic "technical reviews," intensive workshops at which research progress is assessed by a body of outside scientists. Examples of review topics planned are: subjective and objective measures of withdrawal and craving; psychopathological aspects of drug abuse treatment; economics of drug abuse.

A third form of monitoring occurs through a computer system the Division of Research has developed call the Drug Abuse Research Project Information System (DARPIS) that includes a description of all Federally funded drug abuse research projects. From this, an annual publication, the Federally Supported Drug Abuse Research Survey, is produced. The computer system survey includes the research projects of 30 agencies concerned with drug, alcohol, and tobacco research. The Annual Survey not only provides a means for locating any duplications or overlaps in research but also allows assessing relative funding levels of different program areas.

A fourth form of monitoring undertaken is the Division's ongoing Research Analysis and Utilization System (RAUS). This is a procedure for the systematic review of research findings by sorting them into topic "clusters," each of which defines a specific research objective. Each cluster is then assigned to a reviewer; a review of the findings within the cluster is written and the reviewer meets with staff to evaluate, consider what action is called for, and what transfer or utilization of findings should take place; the "state-of-the-art" reviews are disseminated as appropriate to scientists, administrators, treatment professionals, and the interested public. In addition, our proposed Program Projects for fiscal year 1980-84 will contain core support for interdisciplinary reviews of various drug abuse areas. These papers can then be published in the NIDA Monograph Series.

Finally, NIDA plans to include in its Program Projects a so-called core support whose function would be to screen and synthesize new knowledge in the drug abuse area. This would include an analysis of the information obtained through past research efforts, as well as current data, and the Program would make projections and recommendations concerning the implementation of new initiatives. For example, many different government programs are presently being funded in the area of cigarette smoking. The core of a designated Program Project would analyze information on the problem from this wide variety of sources which includes ADAMHA, various NIH Institutes, Department of Agriculture, Department of Defense. This information would be useful in planning new programs, reducing the duplication of effort that may occur, and in ensuring that findings from one Agency that are relevant to the mission of a second Agency are appropriately disseminated.

The estimated cost of the research management and utilization program is $0.5 million.

The President has recommended an increase in NIDA's research budget. What are the current trends in research planning for the future?

What are your other research priorities? Could you supply further detail for the record?

The NIDA research program will continue focusing on basic and applied research concerned with the prevention and treatment of drug abuse. The following is a list of areas of high programmatic priority:

1. Continued development of LAAM and naltrexone.
2. Development of a new narcotic treatment drug, buprenorphine.
3. Development of the clinical significance of the opiate receptor and endogenous morphine-like substances.
4. Studies of the physiological and psychological mechanisms of nicotine addiction.
5. Studies of PCP abuse.
6. Studies seeking to identify the biomedical factors that can be used to predict those at risk of abusing drugs.
7. Studies seeking to identify those individuals who are at risk of having adverse reactions (psychologically and physiologically) to drug abuse.
8. Development of Behavioral Medicine Centers.
9. Investigations of the effects of social policy on drug use.
10. Investigations concerning the relation of family to drug abuse.
11. Problems of addicted infants.
12. Examination of the factors influencing the cessation of drug abuse.
13. Creation of a Drug Abuse Data Services Center.
14. Improve epidemiological techniques and study the problem of hidden heroin abuse.
15. Studies of depression in addicts.
16. Develop basic information on the effectiveness of education programs on the prevention of drug abuse.
17. Studies of individuals in high risk environments who are "immune" to the drug abuse epidemic surrounding them.

18. Studies of the relationship of crime and drug abuse and of the economics of drug abuse.

19. Hazards of teenage marihuana use.

20. Continued studies of inhalant abuse.

Further development of these topics can be found in the enclosed copies of the Division of Research's Five-Year Forward Plan and Drug Abuse Research Budget Highlights.

What, if any, research is being conducted on the effects of multiple drug abuse--particularly alcohol and prescription drugs? Alcohol and illicit drugs? How widespread is polydrug abuse? Are there currently any joint research projects conducted by NIDA and NIAAA?

A major source of data on polydrug use is the biannual national survey of drug use. This project, which deals with the use of both licit and illicit drugs, is one source for estimation of the incidence and prevalence of drug abuse in this country. Although use of illicit drugs is undoubtedly underreported, best estimates indicate that the use of tobacco, alcohol, and to a lesser extent marihuana, is widespread. The 1977 survey estimates that over half (58.0 percent) of all adults and about a third (31.2 percent) of all youth regularly use alcohol. About half of the youth and two-thirds of the adults have smoked cigarettes with 20 percent of the youth currently smoking. The incidence of alcohol and tobacco use has not changed between 1976 and 1977.

In contrast, marihuana use has increased significantly in the past year with one in four young adults currently using marihuana. Among youth, 24.5 percent report trying marihuana at least once and 8.2 percent are current users.

Use (at least once) of a drug "stronger than marihuana" is reported by about one in four young adults, one in ten youth, and one in twenty-five older adults. Approximately 1.0 percent of all adults currently use cocaine (3.7 percent of young adults, 0.5 percent of older adults) and 0.8 percent of all youth state that they are current cocaine users. 1.1 percent of youth report having tried heroin at least once and 1.4 percent of adults have tried heroin but less than 0.5 percent of any age group are current users.

Inhalants, hallucinogens and other opiates (including methadone) account for a low percentage of the drug abuse problem, current use ranging from less than one percent to two percent. Stimulants, sedatives and tranquilizers, available by prescription, have been used at some time by three to five percent of all youth and five to eight percent of all adults. Current use tends to fluctuate around one percent for both youth and adults, although among young adults (age 18-25) about three percent are current users.

The extent of multiple drug use in these groups is difficult to determine but undoubtedly extensive if one includes alcohol, tobacco and marihuana in the definition of "polydrug use." Most of the polydrug studies NIDA funds are studies of the epidemiological patterns and attitudes regarding drug use, ethnographic studies of drug use in special groups (hispanics, women, students) or development of methodology and statistical models to predict and/or analyze drug use.

NIDA has over 70 projects active in FY '77 or '78 which investigate multiple drug use. The expenditure for such projects was about 4.3 million in FY '77. Additionally, there are many projects which investigate specific combinations of drugs such as alcohol and Valium (11 projects) or barbiturates and amphetamines, etc. The list of possible specific combinations is too extensive to present in this document but a few examples may be of interest:

- A project which seeks to follow a group of 120 "troubled" children in order to investigate current drug and alcohol use and how they are related to individual, family and school variables identified ten years ago. (P01 DA-01070)
- A grant to develop methodology to identify and gain access to youthful multiple drug users in their natural setting. (R01 DA-01083)
- A study of the epidemiology of drug and alcohol use among native American adolescents. (R01 DA-01054)
- A study of drug taking behavior by blue collar workers and the relationship to job, home life and recreation. (P01 DA-01080)
- A series of experiments to investigate the effects of nicotine and alcohol on smoking behavior. (R01 DA/AA-01935)
- A study of the correlations between levels of drugs (Valium, marihuana, barbiturates) in a biological sample and the impairment of driving performance. (271-76-3316)
- A project to provide critical evaluation of studies of the interaction effects between sedatives and stimulants. (ADM-45-74-146)

NIDA has 45 projects which involve alcohol and drugs (active in fiscal years 1977 or 1978). About a third of them investigate some aspect of interaction between alcohol and drugs, usually interaction with illicit drugs. Two projects are primarily concerned with alcohol and tobacco use and six are concerned with alcohol and marihuana use. Except for a project which focuses on the effect of alcohol and certain licit drugs on driving behavior, none of the research is exclusively concerned with the interactions between alcohol and prescription drugs. Such research is more likely to be funded by the National Institute on Mental Health.

With respect to joint NIDA/NIAAA projects, NIDA currently sponsors two grants in cooperation with NIAAA: a grant to study the interactive effects of nicotine and alcohol on smoking behavior and one which seeks to study the growth and development of the offspring of drug and alcohol abusers. Additionally, in FY '76, NIDA completed an interagency agreement for the inclusion of questions regarding drug use in a survey of juvenile substance abuse conducted by NIAAA.

One other joint venture should be mentioned in the context of drug interactions: NIDA and NIMH jointly sponsor a study of the correlation between smoking, drinking and caffeine use (an animal study).

Attachment: A listing of all NIDA projects active in FY '77 or FY'78 which
involve alcohol.

One of NIDA's research priorities is the relationship between criminal penalties and drug abuse behavior. What findings are available regarding the overall relationship? Please supply further details for the record.

The evidence is compelling that drug use/abuse and criminality are statistically related. The largest body of literature on the topic consists primarily of studies detailing the percentage of arrestees with either a known history of drug abuse or the percentage who show up positive for drug use in urinanalysis screening procedures. A number of these studies have been conducted in the District of Columbia and interface data from the Narcotics Treatment Administration (NTA) with data from the Superior Court Urine Testing Unit.

- Kozel, DuPont, and Brown (1972) found that 45% of a sample of male arrestees admitted to the District of Columbia jail in 1969 were identified as heroin users at the time of their arrest.

- Bass, Brock, and DuPont (1976) found that the comparable figures in 1971 for the District was 47% and in 1973 it was 22%. The door to the criminal justice system in the District is not a portal through which one is likely to pass only once, especially if one also is a heroin abuser.

- Out of 17,534 arrestees in D.C. in 1974, 50% (8,721) had a prior arrest. Some 39% of those with an arrest for drugs in 1974 had a prior arrest. The figures for larceny, burglary, and unlawful entry,crimes often associated with drug abuse were 51, 60 and 46 respectively -- 59% for robbery (See Forst, Lucianovic, and Cox, 1977). These researchers also used the PROMIS system (Prosecutor's Management Information System) to track 222 persons arrested in D.C. for drug law violations. Some 27% of the first rearrests after the initial case was for drug law violations while a total of 39% of rearrests were for larceny, robbery or burglary -- 15, 14 and 10% respectively.

- One of the first and most complete studies of the association between drug use/abuse and criminal behavior was conducted by Eckerman and his associated (1971). Excluding minor offenses, they sampled arrestees in six major cities and discovered that the percentages of current heroin users, defined by both urinalysis and interview, ranged from 16 to 23 for five of the cities and was 53 for New York City. The ranges for current amphetamine and current barbiturate use were 3 to 20 and 8 to 31% respectively.

- Using urinalysis results from over 37,000 admissions to the D.C. Superior Court Lock-Up between December 1971 and April 1975, Kozel and DuPont (1977) report that 24% (9,120) were positive for one or more drugs -- a total of 5,981 or 16% of the total number of admissions were positive for morphine/quinine. Of the over 9,000 drug positive admissions, two-thirds were positive for morphine/quinine, 30% for phenmetrazine and 28% for illegal methadone.

- In McBride's (1976) study of 5,993 individuals arrested in Dade County, Florida in 1974-75, some 16% were current heroin users compared to 3% for amphetamines and 10% for tranquilizers or sedatives. McBride concludes that: "There is a relationship between drug use and crime and type of drug use and type of crime. Those who use "hard" drugs account for more than their share of income-producing crimes against individuals and property."

- Barton (1976) found that 21% of a nationwide sample of state prison inmates had used heroin daily and that 14% were using heroin daily at the time of arrest. Daily use of amphetamines or barbiturates was reported by 11 and 8% of the prisoners respectively.

- McGlothlin (1977), using data in most instances from 1976 or 1977, estimated the point prevalence of heroin users in various segments of the criminal justice system in California (e.g., jails, probation, state prisons, prison parole, youth authority institutions and parole, the Civil Addict Program which includes both incarceration and parole statutes, and those in federal institutions or on federal probation and parole). The overall estimate was that 44,000 (18%) of the 250,000 under supervision of the California criminal justice system were heroin users.

Debate continues about whether drug abuse is linked to crimes against the person (i.e., the assumption that drug abuse causes one to lose control over judgment and thus is more likely to harm others than one who is not using or abusing drugs). We do not assume here that drug abuse implies a pharmacological "CAUSE" of anti-social aggressive behavior. This "type" of connection has been supported by studies on amphetamines, phencyclidine, and alcohol, but such studies do not exist with regard to marihuana and opiates.

- Inciardi and Chambers (1972) found that 29% of the male and 28% of the female addicts in their study admitted committing assaultive robberies and 32% of the males admitted committing armed robberies. They concluded that: "...the contemporary narcotic addict is much more likely to commit crimes against persons than his counterpart of recent years." This conclusion is not consistent with that reached by a more recent study.

- Kozel and DuPont (1977) in a study among arrestees at the D.C. Superior Court Lock-Up found that: "...those testing positive for drug use were somewhat less likely to be charged with the major crimes of violence, i.e., murder, rape, or assault compared to drug-negative admissions.

While 6 to 7% of all drug-positive admissions were charged with violent crimes, almost 17% of drug-negative admissions were so charged. However, Kozel and DuPont noted that those positive for heroin only were charged with a significantly higher number of violent crimes than those who tested positive for heroin in combination with other drugs. Even so, the heroin only group is still considerably below the drug-negative group vis a vis number of violent crimes.

- Weissman, Marr, and Katsampes (1976) interviewed a serial sample of 167 male and 33 female self-admitting addicts as part of a TASC project in Denver in 1973 and 1974. They found that the onset of addiction is strongly associated with large increases in property crime (arrest rates for larceny and burglary more than doubled, pre- to post addiction). These increases were not limited to income generating property crimes -- arrest rates for robbery doubled and the assault rates nearly tripled.

There is also a great deal of concern about the efficacy of various types of treatment vis a vis reductions in criminality and drug abuse and increases in the functioning of addicts in the community.

- Ellis and Stephens (1977) found that there were sizable increases in both arrest rates and percentages of persons arrested in the year prior to treatment among addicts admitted to the New York State Drug Abuse Control Commission from 1 April 1967 to 31 March 1971. They discovered that criminal behavior at least that measured by arrest rates, decreased substantially when one year after admission is compared to the year before entry into treatment. The decrease is less dramatic if one is comparing the 3 years before entry with the three years after admission to treatment.

- Kleinman and Lukoff (1977), in an evaluation of a large methadone program in New York, found that prosocial changes were limited almost exclusively to those patients who remained in the program for more than three years. The changes that did occur in heroin use and criminal behavior occurred in the first year after entry into treatment -- changes in successive years were minimal. They state: "When the overall charge rate is broken down by type of charge, we find that the rate of assaultive charges is higher two years after entry into the program than it was even in the peak of crime one year before entry period, while the rate of charges for misdemeanors, larcenies, and felonies was almost as high in the two years after period as it was in the year before entry. The only real decline is in the drug related charges."

In perhaps the most thorough and comprehensive review of the literature on the effects of treatment on criminality and drug abuse, Nash (1976) concludes: "There have been a number of reviews of the literature and methodological critiques of the literature. Most have concluded that there is no proof that drug abuse treatment has an impact on criminality. Despite problems caused by methodological shortcomings and noncomparable data, we feel that the weight of the evidence from the 12 major studies reviewed in this paper clearly indicates that drug abuse treatment can reduce criminality."

I understand that you are exploring the relationship between depression and heroin addiction - based on the finding that an inordinately high proportion of heroin addicts exhibit clinical depression. Could you elaborate for the record on these studies and any preliminary findings?

Traditionally, the field of drug abuse has been content with pharmacologic diagnosis; i.e., patients have been classified according to the type of drug they habitually used. It has only been recently that the heterogeneity among the group diagnosed as heroin addicts has come to general attention. The most important study in this regard was done by Weisman and her colleagues, when they showed that approximately one-third of heroin addicts applying for treatment were moderately to severely depressed, when measured with standard diagnostic rating scales and rated according to established criteria. (Weisman et al., 1976) Woody et al. have published a clinical trial of doxepin vs. placebo in a patient population maintained on methadone who were also diagnosed as depressed. (Woody et al., 1975) The duration of this study was short, only 6 weeks and, therefore, it can only be considered a pilot study. However, the data showed a statistically significant improvement, not only in the depression in patients who received doxepin, but also an increased compliance with methadone maintenance in terms of clinic attendance, retention in treatment and decreased use of illicit drugs. The study of Woody et al. gives a strong indication that a diagnostic subcategory of heroin addicts who are depressed could have great clinical relevance. Speaking more generally, psychiatric diagnostic criteria and treatments specific for those diagnoses have evolved greatly in the last several years, and the field of drug abuse should be able to reap the benefits of this evolution.

What is the status of research of naltrexone and other drugs intended to block the effects of opiates? Could you supply further detail for the record?

Naltrexone research is almost exclusively devoted to drug development. Data has been collected on over 1,000 patients who have received naltrexone, and a contract is currently being negotiated with the company which holds the patent on naltrexone, ENDO, to conduct the Phase III clinical trials and prepare and submit the New Drug Application (NDA).

The results of the Phase II clinical studies with naltrexone had been encouraging to the extent that naltrexone has been shown to be safe and efficacious. Phase III data must be collected on as unselected a patient population as possible to reflect the actual use of naltrexone in clinical practice. Under the current plan, it will take at least four years to complete Phase III, to prepare and to submit the NDA. Unpredictable delays may occur in the review process at FDA or the review process at OMB.

Some of the preclinical toxicity testing of naltrexone was conducted by Industrial Bio-Test (IBT). The integrity of the work performed by this company has been questioned by the FDA, and we are in the process of auditing the preclinical toxicity studies done by IBT. Unforeseen delays would also occur if these studies were found to be unacceptable and had to be repeated.

There are currently no other antagonist drugs being studied. However, buprenorphine is a mixed agonist-antagonist and may hold some promise for the treatment of heroin addiction. Thus far, no definite plans for future clinical testing have been made, but the company which manufactures buprenorphine, Reckitt and Colman, has expressed an interest in developing buprenorphine for that indication. It is probable that clinical testing of a preliminary nature will begin in the next fiscal year.

What is the status of LAAM? When may this be available for full-scale implementation? Could you supply further detail for the record?

LAAM continues in the status of an experimental drug. Phase III clinical trials with LAAM are nearing completion. (Phase III is the final clinical testing phase).

A New Drug Application (NDA) for LAAM is currently being prepared. (The NDA will permit LAAM to be marketed for use in the treatment of heroin addiction). An NDA is an extensive document, often in excess of a hundred volumes. It contains all individual patient data, as well as extensive information on the chemistry, pharmacology, pharmacokinetics, and various summaries and analyses of the preclinical and clinical studies conducted with a drug. We are hopeful that we will be able to complete this task to the satisfaction of the Food and Drug Administration (FDA) over the next six months or so. It is difficult to estimate the time, because the NDA requires the concurrence of the FDA; and NIDA, of course, has no control over that concurrence.

Subsequent to submission of the NDA, time will be required for the FDA to review such an extensive document. We have assurances from the FDA that the time for review will only be in terms of months. Thus, if all goes smoothly and our submission is judged to be adequate, we are still at least a year away from making LAAM available.

The FDA has only recently given us permission to begin studying the effects of LAAM in heroin dependent females. We are in the process of designing studies to test LAAM in females. Again, the form which the final studies take and the extent of these studies, in terms of the numbers of patients required and the length of time of observation and the relationship of the studies to the approval of the NDA are all dependent on the concurrence of the FDA, and consequently not directly under the control of NIDA, making it difficult to predict the amount of time required for completion.

A separate issue is the questioning of the integrity of Industrial Bio-Test (IBT), the company which performed the preclinical toxicity studies for LAAM. Thousands of studies performed for many companies in the pharmaceutical industry have also been questioned. NIDA is in the process of attempting to revalidate these studies. If, in fact, our audit shows that the studies were improperly conducted, they will have to be repeated. Again, it is difficult to predict the outcome of the audit, although no serious flaws have been found to date, and it is equally difficult to predict the concurrence of the FDA with the results of our audit, should they prove favorable, and with the ultimate effect that all this will have on the approval of the NDA.

Finally, there is the issue of the regulation of LAAM. A recent meeting with the FDA indicates that there will be a good deal of discussion necessary between NIDA and the FDA to arrive at regulations which will permit the widespread use of LAAM in the place of methadone. It has never been the intention of NIDA to force clinicians to use either LAAM or methadone. Rather, it has been NIDA's intention to provide clinicians with an alternative to methadone which would permit them to use LAAM on an equal footing with methadone and thus be able to take full advantage of LAAM. It is NIDA's feeling that the regulations governing the use of LAAM must be integrated with the methadone regulations to provide comprehensive guidance to clinicians treating heroin addicts with the maintenance modality.

Thus, as you are aware, a mountain of information has been collected on the action, the effects, the safety, and the efficacy of LAAM (and methadone concurrently) and a great deal of work for both NIDA and the FDA remains to be done.

What about synthetic analgesics? As substitutes for heroin? Could you supply further details for the record?

The search for a potent analgesic, free of addiction liability and other side effects, continues to receive considerable support from both industrial and government sources. Bolstered by the discovery of analgetic activity in certain opioid antagonists (usually referred to as narcotic antagonists), much work has focused on this type of compound. The prototype of this group, pentazocine, has only partially met the widely sought goal, and, due primarily to a recent surge in diversion and misuse, has been recommended for placement in Schedule IV.

New drugs of the antagonist-class have emerged from these research efforts. Three are currently under extensive clinical trials. These are nalbuphine, butorphanol, and buprenorphine. All are potent analgesics, orally effective and appear to have minimal side effects. They have been tested in cancer patients, in addition to many others, and have shown good promise. At least one should be available on the market in the near future.

Because heroin is not available for use as an analgesic, except in England and to a lesser extent in France, there is no reason to consider these new drugs as a "substitute" for heroin. Although heroin was removed from usage because of its high addiction liability and demand, it has several clinical disadvantages. Its actual value relative to other available narcotic analgesics is currently being evaluated in a study being supported by NIDA at the Sloan Kettering-Memorial Institute. The National Cancer Institute is also planning some additional studies on heroin.

Several narcotic analgesics have been available for many years. All are effective analgesics that offer comparable pain relief to heroin. These drugs include morphine, methadone, meperidine, dilaudid, oxymorphone, oxycodone, levorphanol anileridine and piminodine. Most are orally effective and are available as stable and sterile injectable preparations. Heroin is neither.

There has been a renewal of and intensified interest in analgesic research with the discovery of the endorphins. In addition to providing leads to the design and synthesis of related compounds, this group of natural pain relievers is likely to give further insight into the mechanisms of pain and analgesia.

In fiscal years 1976, 1978, and 1979, $7 million was authorized under Sec. 503 of the Drug Abuse Office and Treatment Act for research on drugs to replace opium and its derivatives in medical use, and on drugs used for treatment of heroin addiction. What activities have been conducted pursuant to this provision? What findings have been made?

We have already referred to the development of snythetic analgesics and new treatment drugs for heroin addiction. This research was conducted with research funds from our operating budget. Although $7 million was authorized under Sec. 503, this money was not appropriated for research by this Institute.

In particular, could you comment on the status of research on LAAM (longer acting methadone), Naltrexone (blocking agent), and endorphins?

Research on LAAM and Naltrexone has already been discussed. In regard to endorphins progress during the past year has continued in the area of our understanding of the role of naturally occurring morphine-like substances in the brain. One of the more interesting results is that it is becoming more and more obvious that we have to deal with more than one kind of receptor and with more than one kind of endogenous opiate. The evidence suggests that there are at least three and possibly more types of opiate receptors, each with distinctly different properties and effects. The endogenous opiates may also have to be viewed not as homogeneous entities but as at least two functionally distinct units. The smaller enkephalins appear to be distributed and function like neurotransmitters while the larger endorphins appear to act more like hormones, carrying messages between the pituitary and other organs including the brain. Intense work is underway in several laboratories to clarify these problems and to explore their role in the various aspects of opiate addiction.

In the area of basic research with the smaller endorphins (metenkephalin and leuenkephalin) progress is being made in exploring the neural substrates in which these endogenous peptides may operate as transmitters or modulators. They can be released by nerves, to combine with opiate receptors on other nerve cells, and they can be destroyed quicky to permit fine on-off control. When they (or opiates) combine with the receptors, the activity of the cell bearing the receptors is usually depressed. Thus, they appear to fit into the category of inhibitory neurotransmitters.

The most clearly understood action of enkephalins is in the spinal cord, where small enkephalin-containing neurons impinge on the terminals of the nerve cells that convey pain information to the spinal cord. These primary afferent neurons contain (and release) another peptide known as substance P, and the application of enkephalin (or opiates) depresses the release of substance P. In this manner it is thought that pain stimuli can be suppressed at the very point where they enter the central nervous system. But enkephalin-containing neurons are found at higher levels of the pain pathways, and in the areas of the brain that are thought to connect pain impulses with emotional responses to pain.

The function of the pituitary endorphin is less clear. The pituitary gland, both in its anterior and intermediate portions, contains a very large amount of Beta-lipotropin and of endorphin (derived from Beta-lipotropin). There is a very close relationship between Beta-lipotropin and corticotropin (ACTH) in the pituitary; indeed, they are synthesized together as a single large precursor molecule and it was shown that severe stress in rats causes the depletion of endorphin in the pituitary and its release into the circulating bloodstream. Since ACTH, which acts on the adrenal cortex, is clearly involved in responses to stress, it is surmised that pituitary endorphin also plays a role in such responses. But the target organ upon which pituitary endorphin acts remains a mystery. It seems unlikely that this large peptide passes from the blood back into the central nervous system. Recently, however, it was shown that the smaller enkephalins can cross the blood brain barrier.

The role of endorphins in clinical processes other than pain perception remains under intensive investigation. Both Beta-endorphin and the antagonist naloxone are being tested in psychiatric patients such as schizophrenics and manic-depressives with variable results and the data so far does not allow any definitive conclusions on the possible role of endogenous opiates in these diseases.

I understand the Department of Defense has discontinued its drug abuse research. Will NIDA assume the responsibility for this research? What subjects will be studied?

Our proposed budget for FY 1979 requests $924,000 for DOD related research. If these funds are appropriated we will attempt to support projects applicable to both military and civilian populations which would come through the NIDA peer review system. Subjects such as drugs and driving performance, the effects of drugs on visual signal detection, and possible enhanced performance from drugs would be considered. We anticipate that a substantial segment of research formerly supported by the DOD would not be recommended for funding because of either scientific or programmatic concerns.

NIDA does not anticipate that it will support research specific to the relationship of drug use to the question of troop readiness since these must be conducted in the context of military operations.

NIDA is supportive of a joint interagency program which would manage research of interest to both the DOD and DHEW. Projects such as the mechanism by which heroin epidemics occur in military service, the effects of alien cultures on drug abuse practices of armed forces personnel, the effectiveness of specific treatment programs and urine screening surveillance would then be jointly encouraged.

What is the relationship between licit drugs (alcohol and tobacco) and later drug abuse?

1. Denise Kandel (1975), in her studies of adolescents in New York State found distinct "stages" of involvement in drug abuse. The four stages she delineated were:

I. Beer or wine or both
II. Cigarettes or hard liquor
III. Marihuana
IV. Other illicit drugs

> "Drug use starts with legal drugs, which are a necessary stage between nonuse and illegal drug use. A direct progression from nonuse to illegal drug use practically never occurs."

> "The types of changes and the sequences in patterns of change are strikingly similar in both cohorts and are found in all grades in high school, in both sexes, and are independent of family educational background and race."

Basically, Kandel suggests that there is a progression into drug use--it starts usually with beer or wine or both. The probability of moving to Stage II is heightened once one has encountered State I. Stage III is affected by involvement with Stage II types of drugs.

Kandel notes that marihuana is a key drug to consider in the progression to illicit drugs "beyond" marihuana. "Sequences of changes involving adolescents in our samples who were already using legal drugs at the initial interviews demonstrate that marihuana use is a crucial step in the induction into illicit drug use."

Kandel implies that use of alcohol and tobacco are more than temporally related to use of marihuana. The way she has analyzed the data from her study does not allow one to make the inference that alcohol and tobacco use are "causally" related to induction into illicit drug use, whether by that we mean use of marihuana or use of other illicit drugs.

Denise Kandel, "Stages in Adolescent Involvement in Drug Use." Science 190(28 November 1975): 912-914.

The question about the relationship of licit drug use and later drug abuse can be interpreted several ways. One way is usually called "gateway" -- this refers either (a) to the possibility that there is a pattern to the temporal order in which various drugs are encountered with the gateway drugs coming first and thus providing some impetus to use of other drugs further down the usual temporal ladder toward abuse or (b) the possibility that some of the so-called gateway drugs are causally related to subsequent drug abuse or use of illicit drugs. Another name for this process is the stepping stone hypothesis.

The study by O'Donnell et al. (1976) provides some pertinent information about the phenomenon of movement from one drug to another. The O'Donnell study is of 2,510 men representative of all men born between 1944 and 1954. All of these men were personally interviewed and their names were randomly selected from Selective Service files.

Some of the findings are listed below:

1. The following percentages of men used the various drugs: alcohol, 97%; tobacco/cigarettes, 88%; marihuana, 55%; stimulants, 23%; psychedelics, 22%; opiates other than heroin, 20%; sedatives, 16%; cocaine, 14%; and heroin 6%. Only 45 of the 2,510 men interviewed, 2% has never used any of the drugs listed above; 7% had used only alcohol; 33% has used only alcohol and tobacco; and 22% had used only alcohol, tobacco and marihuana.

2. In terms of time order of usage, alcohol is clearly a gateway drug with regard to all of the other drugs listed above -- it is used first by those who have both alcohol and the other drugs listed above in over 9 out of 10 instances. Likewise, marihuana use precedes use of psychedelics for 80% of the men who have used both substances, 73% for stimulants, 84% for sedatives, 90% for heroin, 77% for other opiates, and 99% for cocaine. There is little doubt that alcohol and tobacco use antedate use of marihuana in most instances and that marihuana is usually the first illicit drug used for those who have used marihuana as well as other illicit drugs.

A more difficult question to answer is whether the gateway drugs are causally related to subsequent illicit drug use (i.e., use of illicit drugs "beyond" marihuana). One way of testing this is to examine the correlation between use of these drugs (alcohol, tobacco, marihuana) and use of other illicit drugs, in particular, heroin. A substantial correlation exists between use of any drug and use of all other drugs. Stated differently, those who use any drug, even alcohol and tobacco, are more likely than nonusers to use other drugs.

A more important test of the hypothesis that use of a gateway drug is "causally" related to use of illicit drugs beyond marihuana is to introduce statistical controls on the drug by drug relationship. For example, if alcohol is "causally" related to heroin use; controlling on use of marihuana should make the correlation between alcohol use and heroin use disappear. This should occur because all of the variation in heroin use "caused" by alcohol use can be explained away by the intervening influence of marihuana use.

Using the national sample of men, O'Donnell and Calyton show that neither alcohol use nor tobacco use are causally related to heroin use, psychedelic use, or use of cocaine. The reason they are not statistically related in a "causal" sense is that the intervening influence of marihuana use is so strong. When time order has been shown/demonstrated, it should be possible to see if heroin use is affected by an indirect influence of alcohol and tobacco use THROUGH marihuana use. O'Donnell and Clayton examined the correlation between marihuana use and heroin use, simultaneously controlling for both alcohol and tobacco use -- the relationship did not diminish. In fact, when O'Donnell and Clayton examined the marihuana-heroin relationship while simultaneously controlling for the influence of 31 variables antecedent to use of both drugs, the relationship remained and was still statistically significant. The conclusion they reached is that while all three gateway drugs are temporally prior to heroin use, psychedelic use and cocaine use; only marihuana use is "causally" related to use of these other illicit substances.

John A. O'Donnell, Harwin L. Voss, Richard R. Clayton, Gerald T. Slatin, and Robin G.W. Room. Young Men and Drugs: A Nationwide Survey. Rockville, Md.: National Institute on Drug Abuse, 1976.

John A. O'Donnell and Richard R. Clayton, "The Stepping-Stone Hypothesis: Marihuana, Heroin, and Causality." Paper to be read at the American Sociological Association meetings, Sept. 1978.

Could you undicate now, and furnish in more detail for the Record, NIDA current and planned initiatives with respect to PCP--Phencyclidine, or Angel Dust, as it is known popularly. Research? Education/Prevention? Treatment?

NIDA research in the area of phencylcidine (PCP) abuse will be increased in the next few years. Studies on phencyclidine and phencyclidine-like drugs are specified as an area of high programmatic concern by the NIDA Division of Research in its February 1978 Announcement of Areas of Special Interest. Investigators are invited to submit proposals for research on basic sociological, psychological and biomedical aspects of phencyclidine and similar drugs. Eventually these should make it possible to develop more effective methods of treatment and prevention of PCP abuse.

In advance of its current major emphasis on PCP, the NIDA Division of Research has funded in FY 1978 four extramural research programs which give substantial attention to PCP, with an estimated $155,257 for PCP-related research. In FY 1977 there were also four projects, for $208,572; and in FY 1976 and the transition quarter, seven projects were funded, for $170,207 in PCP research.

An intramural research program is also underway at the NIDA Addiction Research Center, in Lexington, Kentucky, working with analogs of PCP, of which there are many, to establish a pharmacologic profile for PCP and then to compare a series of analogs, to determine their similarities and differences. NIDA, DEA, and FDA representatives met on May 1 to discuss the synthesis of PCP analogs, now taking place under NIDA contract, and further animal experiments to be carried out under contracts jointly funded by NIDA and DEA in FY 1979.

To review the present state of PCP knowledge and to delineate areas needing further research, a conference of two dozen experts was convened by NIDA on February 27-28, 1978. A monograph based on results of this meeting will be published as NIDA Research Monograph 21, early this summer.

In addition, the draft of a brief statement on PCP, prepared by NIDA staff particularly to meet the immediate need of clinicians for diagnostic and treatment information, was reviewed by the conference participants. This statement is now ready for printing.

Because our present knowledge about phencyclidine is limited, there are many areas in which further research is needed. Broadly, these include:

. Incidence and prevalence of PCP abuse
. Personality characteristics of PCP abusers
. Acute and chronic effects of PCP on psychological and physiological function and performance
. Development of tolerance and dependence
. Effects of PCP in combination with other dr[illegible]
. Development of methods for rapid assessment of PCP and PCP-like compounds in body fluids
. Methods for detoxification and treatment of abusers
. Prevention stategies based on both behavioral and biomedical concepts.

Attachments:

1. February announcement of areas of special interest
2. Computer printouts on PCP related grants/contracts Fy 76 - FY 78
3. Jasinski memorandum on PCP studies at ARC
4. Draft of "Phencyclidine: A Review," by Petersen, Stillman

Could you indicate now, or supply for the Record, HEW initiatives with regard to informing the public about dangers from Paraquat, the herbicide sprayed on marihuana by the Mexican government?

Could you delineate the extent of the health hazard involved, the available means of detecting paraquat, and continuing efforts by HEW?

NIDA has been instrumental in providing the Secretary, DHEW, the EPA and the CDC with data relating to paraquat contamination of marihuana. We have supplied information to the public through a NIDA news release and by way of answering phone inquiries concerning paraquat. However, the NIDA mandate is to provide basic chemical information on samples entering the country which showed contamination and on the smoke from paraquat treated marihuana.

The question of alerting the public to the dangers of this substance is being addressed by the DHEW and the CDC.

Reliable detection of paraquat contamination of marihuana is not possible at this time by any means other than laboratory analysis. Several commercial labs are analyzing samples sent to them by standard methods of analysis. NIDA cannot endorse the reliability of these methods other than to say that most of them of which we are aware are using methods which should be adequate for the purpose. The CDC in Atlanta has been requested by the Surgeon General to do proficiency testing of these labs.

Several home test kits have appeared on the commerical market and these are considered to be unreliable and in some cases blatantly exploitive of the present "crisis" in the marihuana-smoking community. An information memo which is being sent in reply to inquiries on kits for home use is also attached.

What are the effects of mixing alcohol use with drug use?

The reasons for interest in alcohol-drug interactions stem from three different, distinct areas of concern. First, the frequency and degree with which alcohol is used by members of our society means that most, if not all, other drugs will be used with appreciable frequency before or after alcohol. The concerns, then, are clinical and epidemiological in terms of altered actions, changed intensity of effect of either the drug or alcohol and the frequency and importance of such combinations. Of primary importance are the possibilities for increased toxicity of either alcohol or drugs when taken together.

The second concern is the potential for increased understanding of the nature of either the drug or alcohol's action based on studies of interactive effects of two or more agents.

The third concern deals with possible influence of effects or experiences with one agent with respect to the probability of use of a second. For example, does heavy caffeine ingestion during the day predispose one to the use of alcohol in the evening? Does experience with alcohol intoxication in any way predispose an individual to explore or adopt other means of intoxication?

In general when 2 drugs are mixed they produce a combination of the effects of the 2 agents taken separately. Thus, from a clinical point, they are all "additive."

However, there are a few instances of striking antagonism--such as that seen between naloxone and morphine. Of recent interest are reports of antagonism between chlordiazepoxide and alcohol. Marked potentiation of an active drug by a relatively inactive one is rarely observed although there are exceptions such as the toxicity of certain combinations of amphetamine and alcohol, as found by Rech (ADM-45-74-146).

In the past four years, through contracts and grants, the National Institute on Drug Abuse has supported a number of studies to look at interactive effects of drugs of abuse, used acutely or chronically, with other drugs and compounds.

A number of projects have looked at in depth interactions between drugs of abuse and alcohol. Some of these were reported in the publication on Interactions of Drugs of Abuse published by the N.Y. Academy of Sciences, vol. 281, 1976 following a symposium supported under NIDA Contract 271-76-3307.

A specific combination which has elicited a great deal of interest is that of marihuana and alcohol. It has been generally accepted that marihuana (or THC) augmented the effects of ethanol. However, Siemens (DA 01136) studies on the metabolic effects of this combination were negative. He concluded that this additive effect as well as the tolerance and cross tolerance between THC and ethanol were not correlated with drug disposition. Very interesting data have recently been reported by Mendelson (5P01-DA-01676) in his Program Project looking at Polydrug Use. Using operant behavior methods, he has observed that concurrent access to alcohol and marihuana results in a significant decrease in alcohol consumption in 14 of 16 polydrug users studies. This finding is at variance with the original hypothesis that multiple drug access would lead to an increase in the use of one or both of these drugs. However, these subjects were also smoking tobacco, which may be a confounding factor.

J. Dougherty (DA/MH 01778) is studying the effects of tobacco smoking in combination with alcohol, in monkeys self administering nicotine. This study, funded in July, 1977, should provide information on the basic pharmacologic and behavioral mechanisms by which ethanol is known to increase the rate of smoking in man.

A number of projects have looked at the interaction of opiates with alcohol. Mary Jeanne Kreek (DA 00049) studied the effects of small amounts of alcohol on the metabolism of methadone patients chronically treated with this compound who did or did not have an alcohol problem. She found that there was no significant acute drug interaction at the metabolic level between ethanol and methadone. However, ethanol may have a biphasic effect on methadone disposition resulting in increased plasma levels of methadone while alcohol is present and decreased levels when alcohol is no longer present immediately following (or during) chronic alcohol administration.

Ho (ADM 45-74-220) also studied in depth the interactive effects of alcohol and opiates, especially during withdrawal. He showed that acute morphine administration suppresses the severity of ethanol withdrawal and conversely, acute ethanol suppresses the abstinence syndrome produced by opiate withdrawal. However, in further studies, they observed potentiation of alcohol withdrawal in animals exposed chronically to both morphine and alcohol or methadone and alcohol. This group has also studied the relationship between opiate administration and voluntary consumption of alcohol. Acute narcotics (morphine, methadone, LAAM) induced a dose-related suppression of voluntary consumption in mice and rats given free choice between water and alcohol. This effect was transient and disappeared after two consecutive days of morphine administration. However, chronic morphine and morphine withdrawal increased the voluntary consumption of alcohol. Combined administration of morphine and alcohol increased the development of tolerance and dependence on alcohol.

Two studies have looked at the interactions of alcohol with methaqualone. Boggan (DA 01035-03) found that alcohol potentiates the anticonvulsant and hypothermic effects of methaqualone (MQ). Ho (ADM-45-74-220) showed that acute MQ increases alcohol toxicity in mice in a dose-related manner, through changes in metabolism. However, chronic treatment with alcohol decreases the lethality of MQ.

Finally, Rech (ADM 45-74-146) found that the combination of alcohol with amphetamine resulted, in rodents, in decrements in behavioral performance, late onset of unconsciousness followed by death in some animals. These effects were dose related and probably due to changes in the metabolic disposition of these compounds as they found that the decay of amphetamine levels in serum and brain was considerably retarded as a result of combining these two drugs.

Conclusion:

There is no doubt that polydrug use may produce certain health risks due to the additive effects of most of these drugs taken in combination. The study of these effects is very complex due to the fact that different effects are observed if both compounds are taken together or separately at different intervals of time, of if they are taken acutely in patients already chronically treated with another compound. Another important factor is the study of the reversibility of the interactions as a compound may be found dangerous if taken before another, but not if taken after the other. So far, we have merely scratched the surface of this complex problem which is of great public health significance.

When did NIDA first initiate the Statewide Services Contract concept?

Could you supply for the record further details regarding the historical development of this concept over the last four years, the number of slots involved in each year, for each modality, the number of treatment facilities involved, and the structure for accountability?

Could you indicate now or for the record your future plans for this mechanism?

The first three Statewide Service Contracts (SWSC) were let during the May-June 1973 period to the States of New Jersey, New York, and Texas. This initiative was the result of a policy directive issued on February 23, 1973, by Dr. Jerome H. Jaffe, Director, Special Action Office for Drug Abuse Prevention (SAODAP). This policy directive, sent to Mr. Wade H. Coleman, Special Assistant to the Secretary for Drug Abuse, Department of Health, Education, and Welfare, stated in part that:

> General Policy
>
> As a general policy, most of the Section 410 funds intended for treatment projects should be awarded to or routed through Single State Agencies in the form of contracts. In most instances, the Single State Agency will not deliver the service itself, but will subcontract, or designate a state line agency to subcontract, to someone else for the actual delivery of services, or designate a state line agency for service delivery. Over the next few months there should be only two acceptable reasons for giving a direct grant or contract to an organization other than a Single State Agency or a major local general purpose government for drug abuse treatment services. These reasons are:
>
> 1. That, at the time, the Single State Agency is either unwilling or unable to assume the primary coordinating and contracting role, in which case the contract or direct grant may be given to a unit of local general purpose government.
>
> 2. That NIMH has not had time to convert the project from a grant to a contractual relationship for treatment services.
>
> In all cases, the Single State Agency shall have the opportunity to exercise its review and comment procedures.

The second reason should be progressively less acceptable over the next five months. In any event, after July 1, 1973, only the unwillingness or inability of the Single State Agency to accept the responsibility would be a reason for not using funds in this way. Of course, if in subsequent discussions, NIMH and the Special Action Office should agree that portions of Section 410 funds should be set aside for innovative and developmental projects, then the policies requiring the use of these funds primarily as contracts would not apply to that portion of the funds set aside.

Grant Funding

If a treatment grant is awarded, as contrasted with a treatment contract to the Single State Agency, designated state agency, or local general purpose unit of government, it will be on a year-to-year basis, with commitments for support never to exceed three years. The project director will be instructed clearly and explicitly that, at the end of the first year, NIMH will attempt to convert the grant into a contract with the Single State Agency, designated state agency, or local general purpose unit of government for the treatment services which were delivered during the first year of the grant and at rates described in a following section of this paper. Obviously, if at the end of one year, neither the Single State Agency, designated state agency, nor the local general purpose unit of government is able to assume this relationship, and the services developed under the grant are found to be effective and efficient, then the grant can be continued for a second year.

The SWSC concept is a key element in the NIDA funding of drug treatment services, and the number of SWSCs has steadily increased since the first three contract were let in 1973 (see attachments for more detailed information on SWSCs by modality).

The primary mechanism through which treatment services are funded by NIDA is the SWSC. In fiscal year 1977, 67 percent of NIDA's community services program budget of $138,183,000 was awarded through SWSCs. The remaining 33 percent was awarded through direct contracts and grants. In fiscal year 1977, there were 49 SWSC which included 907 first-tier subcontracts. Eighteen of the 49 SWSCs were in their first year of NIDA funding, 11 were in their second year, 15 were in their third year, 2 were in their fourth year, and 3 were in their fifth year. By fiscal year 1980, it is anticipated that virtually all of the NIDA community services budget funds will be awarded by means of SWSCs.

The SWSC mechanism allows for treatment services to be delivered within a State under the authority of the agency responsible for drug abuse planning and coordination for the State (i.e., the SSA). The prime contractor has the responsibility for the administration and coordination of the treatment services under the contract. While ultimately accountable to NIDA, the SWSC provides the SSA, as prime contractor, with considerable flexibility in the management and administration of drug abuse treatment services throughout the State in order to meet changing needs. The SSA identifies and reviews the need for services throughout the State and, in keeping with its priorities, sets forth in the SWSC proposal the distribution of programs and services which it believes will best address this need. The SSA also proposes the mix and cost of the services. The proposal is then reviewed by NIDA, within overall budgetary and treatment slot limitations.

Article III, B.4, of the Special Provisions of the SWSC states that: "The Contractor shall be authorized to approve any budgetary changes within a budget category and changes between categories, as long as the estimated total costs remain unchanged in any Government-approved subcontract without further approval of the Contracting Officer, but with prior notification to the Contracting Officer including a revised Program/Budget Matrix. Contractor shall also have authority to modify or terminate any subcontract and to contract with any other existing Government-approved subcontractor within a project for the services called for in the terminated or modified subcontract without approval of the Contracting Officer, but with prior notification to the Contracting Officer including revised Program/Budget matrices. If a new or replacement subcontractor is to be added, prior approval of the Contracting Officer will be required." The SSA can, thus, decide where treatment programs are to be located in order to most appropriately meet need and changes in demand. They can also, within overall State and Federal budgetary and treatment slot limitations, decide how much each program receives.

The Federal government monitors the prime contractor, and the role of the prime contractor is to administer the contract and monitor the subcontractors. NIDA provides the prime contractor with monies to assist in the administration and monitoring of the SWSC. While the SWSC mechanism necessitates involvement of the SSA, it is a vital and critical involvement if we are to continue to be able to address nationwide treatment needs in an orderly and planned manner. The SWSC mechanism provides not only monies, but also a vehicle to assist the SSAs in carrying out their mandate, under Section 409 of P.L. 92-255, as the planning and coordinating agencies for drug treatment services within the States.

When NIDA funding is used to support treatment and rehabilitation programs through grants or contracts funded under Section 410 of P.L. 92-255, the Institute's Division of Community Assistance (DCA) is responsible for establishing reporting procedures and monitoring the performance of programs vis-a-vis the achievement of program goals and compliance with Federal regulations. A coordinated monitoring program has been established by the DCA. The prime contractor directly monitors the subcontract service providers, and the DCA monitors the prime contractor's overall administration of the SWSC. The Institute has developed and issued a "Statewide Services Contract Policy and Practice Manual" and a "Statewide Services Contract Program Review Manual." These provide guidance to prime contractors in the administration and monitoring of their SWSCs.

The primary responsibility for monitoring the SWSCs, within the Institute, rests with the DCA's Program Development Specialists (PDSs). Regular on-site visits are conducted by the PDSs to verify reported information and to review those aspects of Division supported activity which cannot be fully reviewed on the basis of a written report. Also, all grants and contracts are formally reviewed on a quarterly basis.

At a minimum, the quarterly review addresses: the quality of treatment services provided, utilization of treatment slots, problems identified by DCA through previous review or other means, and general issues specifically identified by the Division.

Division funded treatment and rehabilitation grants and contracts are also subject to intensive program mangement reviews (PMRs) to determine strengths and weaknesses--particularly in the areas of management, financial control, and utilization. This information may then be used for identifying techncial assistance needs, information which can be advantageously shared with other programs, and funding adjustments as necessary. The PMRs are conducted, under contract, by Touche Ross & Company. The contract is administered by the DCA.

In prior years the primary target group for the PMRs was local drug treatment and rehabilitation programs. However, with the shift in management responsibility to SSAs, through the SWSC mechanism, the focus of the PMRs has also shifted to the review of the management of these contracts.

Where a need for technical assistance is identified, this can be provided by PDSs and by Macro Systems, Inc., who is under contract to our DCA for the specific provision of these services. This contract has augmented the capability of the Division to provide direct, on-site clinical technical assistance to specified drug abuse treatment and rehabilitation programs and SSAs. Such directed technical assistance is delivered primarily in the areas of (1) clinical operations, including medical services delivery, health records systems analysis and design, treatment management techniques, and counseling and therapeutic techniques; (2) program operations, including both fiscal and managerial systems and techniques; and (3) in clinical consultation services to SSAs in licensure standards development and other related topics. Programs needing such assistance are identified through SSA or NIDA monitoring site visits, PMRs, or through self-identification by programs or SSAs. This project is intended to continously assist in upgrading the quality of drug treatment and rehabilitation services as they are delivered by NIDA funded programs.

Current PCP Initiatives

NIDA is currently conducting a one-year exploratory investigation of Phencyclidine use in five cities--Seattle, Chicago, Philadelphia, Miami, and Houston. The study is designed to achieve the following objectives:

- Determine the nature and extent of PCP use in the five cities
- Identify the type of PCP users who have come to the attention of hospitals, mental health programs, health systems, social service agencies and drug treatment programs in the five cities
- Determine the types of services provided to PCP users in the five cities
- Identify the treatment protocols that are recommended for PCP users by treatment agencies in the five cities.

A grantee recently completed a study of phencyclidine use by a national sample of 2,756 youthful drug abuse clients representing 97 drug abuse treatment programs. Data from this 1976-1977 client survey indicated that phencyclidine use is widespread. More than 31 percent of the subjects reported current or past use of phencyclidine, with males and females having similar exposure rates. While the sample cannot be viewed as representative, the data do indicate that phencyclidine is in use in all regions of the country with the highest rates reported in the Great Lakes and Midwest regions.

In order to better assess the use of PCP across the Nation, a study is being conducted as an adjunct to the CODAP system to collect data on the use of PCP at the time of admission into federally-funded drug treatment programs.

The study population is a 10 percent random sample of all clinics reporting to CODAP. The random sample of all clinics includes 134 clinics from 37 States and one territory (Puerto Rico) and represents 64 SMSA'a and 21 rural units. Projecting from past experience, we expect to net more than 1,200 admissions per month from this sample.

Data will be collected for four months commencing with March 1978 data. We plan to have a preliminary report by mid or late summer 1978. For the first month, approximately 95 percent of the units in the sample reported admissions to CODAP.

NIDA Capsules

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PARAQUAT: POTENTIAL LUNG DAMAGE

The Secretary of the Department of Health, Education, and Welfare issued a statement on March 12, 1978, cautioning heavy users of marihuana that some marihuana entering the United States from Mexico is contaminated with the herbicide Paraquat and that lung damage may develop from its use.

This statement was based on studies done by the National Institute on Drug Abuse (NIDA) at the request of the White House Office of Drug Abuse Policy.

The studies began with the analysis of some marihuana confiscated near the Mexican border by the United States Drug Enforcement Administration. Twenty-one percent of the samples tested (13 out of 63) were found to be contaminated with Paraquat at levels that ranged from 3 parts per million (ppm) to 2,264 ppm. The average sample contained about 450 ppm. The Environmental Protection Agency (EPA) allowable tolerance for Paraquat on fruit in the United States is .05 ppm.

After confirming that Paraquat-contaminated marihuana was entering this country, NIDA began studies to determine what effects the herbicide might have on marihuana users. In early December of 1977, NIDA stated that there was little risk from ingesting contaminated marihuana since it is estimated that a person would have to swallow several pounds within a few hours, or 2 full ounces every day for 2 years at contamination levels of 2,000 ppm to cause harm.

Analyses of smoking contaminated marihuana were completed last week. Based on numerous studies--involving farm workers using Paraquat, animals inhaling a Paraquat mist, and simulated laboratory experiments--NIDA estimated that there is a possibility that some lung damage could develop in the person who smokes 3 to 5 marihuana cigarettes or "joints" a day with high concentrations of Paraquat (450 ppm) over several months.

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The damage that could occur is fibrosis, a condition which reduces the capacity of the lungs to absorb oxygen. If fibrosis did occur, it would be irreversible and probably not diagnosable until after several months of smoking marihuana contaminated with high levels (450 ppm or more) of Paraquat. It should be emphasized that no lung damage has been identified from smoking Paraquat-treated marihuana.

The Paraquat contaminant itself has no odor, no known taste, and is invisible to the eye. Thus there is no way in which the heavy or casual user can be sure of its presence.

Paraquat has been used by the Mexican Government to eradicate marihuana since 1975. It is sprayed by aircraft and interacts with sunlight to cause the plants to die within about 2 days. The U.S. Government does not fund or provide the pesticide for the eradication program.

Paraquat has been used in the United States since the early 1960's and is a highly toxic and commonly used weed killer. It is approved by the EPA for weed control in fruit orchards and as an aid to harvesting mature plants such as cotton and soybeans.

The only deaths attributed to Paraquat have been from suicide or accidental poisoning from swallowing the herbicide in concentrated form.

INFORMATION MEMO

SUBJECT: Paraquat Test Kits for home use

During the past month a large number of home test kits for detecting paraquat on marihuana have appeared on the commercial market. A few of these have appeared to be sanctioned by state or federal agencies or by legitimate commercial analytical laboratories. In all cases of which we are aware this sanction is false or in error. To our knowledge there is not a kit on the market which will reliably detect paraquat contamination to a minimum of 50 ppm on the plant material itself. This means that no kit presently available is capable of insuring the marihuana user that his material is safe for use. It is true that the means of paraquat detection in solution is straightforward but no process for getting the paraquat off the marihuana and into a solution in sufficient concentration for a reliable detection to safe minimum limits is to our knowledge available.

At the present time the only means for potentially reliable analysis of marihuana for paraquat contamination is by established laboratory procedures which are not applicable to home use.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL

SUMMARY OF CDC ACTIVITIES RELATED TO PARAQUAT CONTAMINATION OF MARIJUANA

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May 1~~2~~5, 1978

CDC ACTIVITIES

I. EPIDEMIOLOGIC AND CLINICAL STUDIES

A. Dose-response study - California. To determine whether there exists a dose-response relation between reported symptoms (mouth ulcers, bronchial irritation, hemoptysis) and paraquat exposure, CDC investigators are conducting blind interviews of persons who have anonymously submitted marijuana samples for qualitative paraquat analysis to a California laboratory. Data on symptom prevalence will be obtained on 500-600 persons before paraquat testing results are given. Tobacco use histories will also be obtained.

B. Pilot dose-response study - California. During the past 6 weeks a drug-abuse clinic in California has collected clinical data and marijuana samples on 758 marijuana users who reported to the clinic with symptoms. For 486 samples on which only qualitative (yes-no) data on paraquat concentration were available, no association was found between symptom prevelance and paraquat presence; however, no systematic data were collected on the frequency of either cough or hemoptysis. Quantitative data on paraquat levels were obtained on 272 samples: 147 (54%) showed no paraquat; 63 (23%) showed 0-9 ppm; 32 (12%) had 10-24 ppm; 12 (4%) had 25-49 ppm; 16 (6%) 50-99 ppm; and only 2 (1%) contained ≥100 ppm.

C. Clinical studies - California. Intensive clinical studies of approximately 40 patients with either hemoptysis (16) or severe bronchial irritation (24) are being undertaken in collaboration with a second drug abuse clinic in California. Studies will include drug and tobacco histories, physical examination, chest X-ray, and pulmonary function testing as well as quantitative testing of marijuana for paraquat levels at CDC.

D. Followup on persons previously exposed to paraquat. Investigators who have previously presented case reports in the literature of acute or chronic paraquat poisoning are being systematically queried as to the presence or absence of fibrotic pulmonary sequelae in their patients. At present, there are few data as to the frequency with which fibrosis follows exposure.

CDC ACTIVITIES

II. LABORATORY ACTIVITIES

A. Reference Method. The Toxicology Branch, Clinical Chemistry Division, Bureau of Laboratories, CDC has developed a reference quantitative method for paraquat analysis on marijuana.

B. Quality Control. The CDC laboratory has contacted 10 laboratories around the country (California -2, Illinois, Florida -2, Georgia, Michigan, Wisconsin, Pennsylvania, Massachusetts) who are conducting or who are about to conduct analyses of marijuana samples for paraquat. All of these laboratories have agreed to participate in a voluntary quality control program in which the CDC laboratory will send out blind reference samples on a frequent, regular basis. The CDC laboratory has also received paraquat home testing kits for evaluation.

III. INFORMATIONAL ACTIVITIES.

A brief summary of available information on paraquat toxicity has been sent to all state health officers and state epidemiologists in the United States (attached).

DRUG USE AND THE ELDERLY

In June 1976, Dr. DuPont, Director of the National Institute on Drug Abuse presented testimony to a joint meeting of the Subcommittee on Alcoholism and Narcotics and the Subcommittee on Aging on drug use and the elderly. Outlined below are some of the issues that have emerged and some of the studies that the Institute has undertaken since then.

- The aged comprise approximately 10.5 percent of our population at this time, yet they are prescribed over 25 percent of all drugs prescribed. Both the large amount of drugs used by the elderly, and the combinations of drugs prescribed and used, contribute significantly to the chances for drug misuse and complications.

- The Institute's report Sedative-Hypnotic Drugs: Risks and Benefits (1977) concluded that males over the age of 60 may experience the greatest risk from sedative and hypnotic prescriptions. This is particularly significant in light of the fact that 30 percent of all Seconal prescriptions (about one million prescriptions) and 30 percent of all Valium prescriptions (over 10 million prescriptions) are written for persons over age 60.

- NIDA jointly sponsored a project with the Administration on Aging (AoA) to explore the patterns of prescription and over-the-counter drug use of a random sample of persons 60 years and older in the Washington, D.C. area. The study revealed that 14.7 percent of respondents reported daily usage of sedative/hypnotic, tranquilizer or anti-depressant drugs.

  Comparison was made of the daily users of these psychotropics with users of other prescription drugs. The following are among the findings that emerged:

  - Almost all users of psychotropic drugs (98.7 percent) indicated that they obtained their prescribed sedative/hypnotic, tranquilizer and/or anti-depressant drugs from a physician. Only 0.4 percent of elderly reported using any prescription drug more frequently than their prescription dictated.

  - Nearly twice as many psychotropic drug users (50.7 percent) reported that they cannot perform normal daily activities without the aid of drugs as compared to the users of other prescription drugs (39.0 percent).

- Users of psychotropic drugs reported about the same percentage (12 percent) of side effects and other medical problems as the users of prescription drugs in general.

- About 90.6 percent of all prescription drug users claimed that they did not have difficulty in obtaining needed drugs.

- All users of psychotropic drugs claimed that they knew what the drugs they were taking were supposed to do, but only 61.2 percent of the users of other drugs claimed similar knowledge.

- A considerably higher proportion of psychotropic drug users took their drugs in combination as compared to users of other prescription drugs (38.7 percent vs. 26.4 percent). Relatedly, psychotropic drug users were more likely to consult with their physician prior to taking drugs in combination than were non-users (75.8 percent vs. 62.4 percent).

- Daily use of alcohol was approximately the same for psychotropic drug users as for non-users (20.8 percent compared to 18.6 percent) while somewhat more users (64.9 percent) abstained from all alcohol use than did non-users (56.2 percent). Only 1.1 percent of all elderly reported drinking problems.

- In short, the use of sedative/hypnotics, tranquilizers and anti-depressants by the elderly residents in the Washington metropolitan area was found to be responsible and appropriate.

A copy of the final report is attached.

- o NIDA sponsored another study to review the literature on the aging process and how it relates to drug use; to review literature on the patterns of psychotropic drug use among the elderly; and to identify programs designed to prevent or treat the problems of drug misuse and abuse of elderly people. The study report entitled Psychoactive Drug Use and Misuse Among the Elderly is currently being edited and will be printed shortly and distributed in the late summer.

- o A research demonstration project is being funded with the University of Kentucky's School of Medicine to test a variety of different techniques for helping the elderly control their drug use. These include training in rational self counseling and education on the purpose and effects of different drugs.

- Through another NIDA study an education program entitled Elder-Ed has been developed to help the elderly use their contacts with physician, nurses and pharmacists to their greatest advantage. The program includes a kit of pamphlets addressing the following:

  - What to tell your physician whenever you meet.
  - What questions to ask your physician, your pharmacist.
  - How to keep track of your medication schedules.
  - How and when to save money on generic name medicines.

  A 30 minute film of a visit to a physician and a drug store are also included.

Other agencies such as the Administration on Aging, the National Institute on Aging and the National Institute of Mental Health have major specific responsibilities for conducting research into the health and welfare needs of the elderly and for providing appropriate services. NIDA shares all of its relevant materials and findings with these agencies and sees its role as supportive of the other agencies.

RESEARCH ON THE EFFECTS OF MULTIPLE DRUG ABUSE

The following research has been undertaken by the Services Research Branch, Division of Resource Development, in the area of multiple substance abuse:

- An experimental study was conducted at the Eagleville Hospital and Rehabilitation Center, Eagleville, Pennsylvania, testing the efficacy of treating alcohol abusers and drug abusers in combined or separate treatment modalities. The sample consisted of 688 subjects, both male and female. The findings from this study are included in a report currently undergoing final technical edit.
- A study was conducted at Eagleville Hospital and Rehabilitation Center involving a large drug-free therapeutic program and 10 different methadone maintenance treatment programs. This study examined the relationship between alcohol consumption and alcohol-related problems and progress through various stages in treatment. The total sample consisted of 764 males and females. This study report has been edited technically and has been sent for final edit and publication.
- A national collaborative study involving 10 programs funded by NIDA and NIAAA is being concluded. This study examines the relationship of 14 substances (including alcohol) plus coffee, tea, and tobacco among 1544 clients in 10 treatment programs nationwide. The 10 programs had been specifically designed to include clients with both alcohol and drug abuse problems. In addition to determining the nature and extent of substance usage, information was collected concerning the consequences of usage of different combinations of drugs, and the characteristics of different groups of clients based on their substance use patterns. This study report is currently receiving a final technical edit within NIDA.
- Each of the 10 programs in the national collaborative project is responsible for independent studies. Four of the 10 programs are still in the process of preparing reports on their findings regarding the combined treatment of alcohol and drug problems. Six programs have already issued reports that are now being reviewed by NIDA for subsequent publication.

Major emphasis in these studies has been in the area of illicit drugs, although prescription drugs--barbiturates, other sedatives, tranquilizers, various amphetamines--have also been included as an area of inquiry.

How widespread is polydrug abuse?

A number of epidemiological studies have been conducted in general population groups.

One study (Chambers et al, 1975 - Chemical Coping) examined interviews with 30,000 people over a four-year period in 30 States. The data collected by Chambers suggests that approximately 35 percent of the users of prescription psychotherapeutic drugs are regular drinkers, and about 10 percent exhibit a drinking pattern which would place them into the "heavy drinking" category. The following table displays further data on prescription psychotropic use and drinking:

REGULAR USE OF PRESCRIPTION
PSYCHOACTIVE DRUGS AND ALCOHOL

Regular Drug Users	Percent Who Are Regular Drinkers (Percent)	Percent Who Are Heavy Drinkers (Percent)
Barbiturates	50	10
Other Sedatives	70	10
Minor Tranquilizers	40	15
Major Tranquilizers	35	10
Antidepressants	20	10
Amphetamine "Pep Pills"	90	50
Amphetamine "Diet Pills"	50	30

Source: Chambers 1975

Much of the data about prescription psychotropics presented by Chambers raises issues about both the population receiving/demanding these medications and the practitioners who are providing them. The Chambers study advanced a number of different projections, some of which are:

PROPORTION OF REGULAR USERS OF
PRESCRIPTION MEDICATIONS WHO USE TWO OR MORE DRUGS

Drug	Proportion (Percent)
Barbiturates	33
Other Sedatives	33
Minor Tranquilizers	15
Major Tranquilizers	1
Antidepressants	50
Amphetamine "Pep Pills"	25
Amphetamine "Diet Pills"	1

Source: Chambers 1975

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Parry (1973) under the aegis of the Psychopharmacology Research Branch of the NIMH discusses patterns of prescription drug use in 2552 people between the ages of 18-74 who were surveyed by probability sampling methods, and who are purported to be representative of a cross-section of American adults living in households. The following table outlines the level of use by the population of psychoactive drug users:

HIGHEST LEVEL OF USE EVERY ATTAINED BY PERSONS WHO USED PRESCRIPTION DRUGS DURING PAST YEAR BY CLASS OF PSYCHOTHERAPEUTIC DRUG

Levels of Use	Minor Tranquilizer/ Sedative (Percent)	Stimulant (Percent)	Hypnotic (Percent)	Anti-Depressant (Percent)	Major Tranquilizer (Percent)	Any (Percent)
High	5	2	1	1	1	8
Medium	5	2	1	1		7
Low	5	1	1			6
Used any	15	5	3	2	1	22
Used none	85	95	96	98	99	78
Totals	100%	100%	100%	100%	100%	100%
Number of Persons	2552	2552	2552	2552	2552	2552

Percentages are based on total population
Less than .5%

Source: Parry 1973

Distribution of the population of current users of minor tranquilizers/sedatives and hypnotics is evenly divided between the three categories; a similar distribution can be observed for the entire population of users.

In a study by O'Donnell (1976) percentages are reported of the use of combinations of different drugs (including alcohol). The data indicates the extensiveness of combined drug usage.
This study examined the prevalence of multiple drug use within a large (N=2510) representative sample of American men, ages 20 to 30. According to the authors, 33 percent of the respondents stated that they had used only alcohol and tobacco. An additional 22 percent reported use of alcohol, tobacco, and marihuana. Fourteen percent of this non-patient sample reported using other drugs in addition to these three.

Abelson and Atkinson (1975) attempted to estimate the extent of psychoactive substance use in America by surveying a nationwide probability sample. Interviews were conducted with 3,701 adults (18 and older) and 952 youths (12 to 17). They reported that 74 percent of the adults and 69 percent of the young people reported no non-medical use of any drug. However, they reported that 10 and 12 percent of the adults and young people, respectively, have used one or more of the following drugs: hashish, LSD, cocaine, heroin, methadone, or other opiates.

The Drug Abuse Warning Network (DAWN), a DEA and NIDA supported reporting system, reports Alcohol-in-Combination as the number two leading mention in 1974-75 with approximately eight percent of the mentions. The data indicate that more than one-fourth of all drug mentions involve three drugs: diazepam, alcohol-in-combination, and heroin.

A summary performed on Client Oriented Data Acquisition Process (CODAP) data for January-September 1975, showed that those primary barbiturate/sedative problems (N=9023) had the greatest alcohol involvement, with 1,064, or 11.8 percent, and 730, or 8.1 percent, respectively, reporting secondary and tertiary problems with alcohol. The CODAP data is based on all clients treated in federally funded treatment programs.

Are there currently any joint research projects conducted by NIDA and NIAAA?

The 10 projects referred to above were part of the national collaborative project supported by NIDA and NIAAA between 1974 and 1978. Two were funded by NIAAA, and the remaining eight were funded by NIDA. Most of these projects are in the process of terminating since they were funded as three-year demonstration programs.

REFERENCES

Chambers, Carl D. et al, Chemical Coping, New York; Spectrum Publications, 1975.

Parry, Hugh, "National Patterns of Psychotherapeutic Drug Use" Archives of General Psychiatry, Vol. 28, June 1973.

O'Donnell, John A., et al, Young Men and Drugs, Rockville, Maryland, National Institute on Drug Abuse, 1976.

Abelson, H.I., and Fishburne, P.M., Nonmedical Use of Psychoactive Substances, (Part 1) Main Findings, Princeton, N.Y., Response Analysis Corporation, 1976.

NIDA Prevention Materials Warning About Mixing Alcohol and Drugs

Below is an outline of the booklets with page number references that address multi-drug usage.

Publication	Page Number
1. Drugs - Use, misuse, abuse - By Margaret Hill (Public Affairs Pamphlet No. 515	4, [illegible]
2. Drug Abuse Prevention Campaign Booklets	
a. "Drug Abuse Prevention"	10
b. "Drug Abuse Prevention for You and Your Friends"	9
c. "Drug Abuse Prevention for Your Community"	14, 18
d. "Drug Abuse Prevention for Your Family"	12
3. Polydrug Use - Special Bibliographies June, 1975, No. 3	3, 12, 21, 26
4. Q & A	14

In addition to NIDA publications, we have included three others produced by NIAAA.

1A. Alcohol Health and Research World
Reprint : Winter 1975-76 Issue on Drug Interactions with Alcohol

2A. NIAAA Clearinghouse Pink Sheet on Dangers, "Its Dangerous to Mix Alcohol and Drugs"

3A. " 'Other Drugs' and Alcohol" (4 pages)

Senator HATHAWAY. Let us take a 5-minute recess and we will call the last panel.

[Brief recess was taken.]

Senator HATHAWAY. The final witnesses this morning will be a panel composed of Susan Wolford, drug abuse program specialist, Office of Alcohol and Drug Abuse Prevention, State of Maine; Larry Monson, chairperson, National Association of State Drug Abuse Program Coordinators for the State of Wisconsin; accompanied by Carl Akins, executive director, National Association of State Drug Abuse Program Coordinators, and William Butynski, Alcohol and Drug Problem Association of North America, who is accompanied by Augustus Hewlett, who is executive director, same program.

STATEMENT OF SUSAN WOLFORD, DRUG ABUSE PROGRAM SPECIALIST, OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION, STATE OF MAINE; LARRY MONSON, ACSW, CHAIRPERSON, NATIONAL ASSOCIATION OF STATE DRUG ABUSE PROGRAM COORDINATORS, AND DIRECTOR, BUREAU OF ALCOHOL AND OTHER DRUG ABUSE, STATE OF WISCONSIN, ACCOMPANIED BY CARL AKINS, PH. D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE DRUG ABUSE PROGRAM COORDINATORS; WILLIAM BUTYNSKI, PRESIDENT, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA, ACCOMPANIED BY AUGUSTUS H. HEWLETT, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA, A PANEL

Ms. WOLFORD. I want to comment on three issues emphasizing the bill to amend the Drug Abuse Office and Treatment Act. Specifically those are drug programing in rural areas, drug prevention activities, and Federal coordination of drug abuse activities.

There exists a major drug problem in the rural areas of this country, indiscriminate use of a variety of legally and illegally obtained drugs, including the drug alcohol. This widespread polydrug abuse is characteristic of both sexes at all age levels. Both alcohol and drug treatment programs in Maine report steadily increasing numbers of people admitted who are abusing one or more drugs.

To date, the largest share for Federal resources of drug abuse treatment has been allocated to large population centers. Rural areas have had to struggle to establish basic levels of service.

The difficulty of that situation has been compounded by the fact that the Federal Government has failed to recognize the greater cost required to operate small programs serving people widely dispersed over large geographic areas.

Furthermore, guidelines for program administration have been tailored to the urban drug abuse problem, and to urban systems of service delivery.

Finally, categorical funding mechanisms at the Federal level have hindered integration of services which are so essential to assure efficiency cost-effective delivery of services in rural areas. We feel strongly that concerns related to rural areas should be addressed by the HEW report to congressional committees which this bill would require. The assistance of those working in rural areas should be actively solicited in preparing that report. I am offering Maine's cooperation in such an effort.

There also exists in rural areas a substantive need for prevention services. Our office is convinced that prevention activities directed at those who are not yet experiencing serious harm from drug use are necessary if we are to alter current patterns of abuse and reduce the problems now created. We have developed a concept of prevention focusing on the use of all drugs, including alcohol, by all potential drug abusers of each age.

We have translated that concept into an intensive communitywide prevention model which requires involvement in key community groups, individuals and institutions, in the effort to reduce drug abuse.

Prevention is also necessary in rural areas because it forms a vital link to treatment services and it is also vital as a method for providing accurate information on drug problems to people who live in smaller, more isolated rural communities.

We therefore support prevention emphasis in this bill, particularly the provision which would require separate appropriation for programs directed at nonusers and marginal uses of drugs.

We strongly urge that the Federal Government consider allocating moneys for prevention programs to the single State agencies in order to assure coordination of a comprehensive statewide prevention effort.

Finally, I want to address the need we see for Federal coordination of drug services. We operate in Maine as a combined agency for alcohol and drug abuse prevention, reflecting the reality of the problem exising of the people we serve. We have developed an approach to specific issues such as prevention training.

We have a particular level of interest between NIDA and NIAAA at the Federal level. Although we observe early signs of willingness to cooperate, we have yet to benefit in a concrete way from that apparent willingness. We support an extension of NIDA's authorization for only 1 year since such an extension would provide us with the opportunity next year when both NIDA's and NIAAA's authorization are considered to come in specific ways in which those Institutes might cooperate to benefit people in our State who need drug and alcohol services.

Senator HATHAWAY. Susan, could you elaborate on additional costs faced by rural programs?

Ms. WOLFORD. What we find in rural areas is that the clinic model of providing services is not real functional when you are talking about covering a large geographic area. What we find is that you need to deploy people into rural towns which may be located at reasonably far distances from central units. The cost of transportation and staff time involved in employing those people increases the total cost to the client.

We find that small programs operating with a smaller volume of clients have out of proportion administrative costs. It still takes an administrator to run a program, and yet his salary distributed over, say, 25 slots becomes much more of a factor than it would if it were distributed over 200 treatment slots.

Senator HATHAWAY. Is the nature of the client any different in rural areas than urban? Are clients younger or older?

Ms. Wolford. In Maine the drug programs that exist are primarily for people between 15 and 25. They are primarily using a combination of drugs, usually including amphetamines, hallucinogens, or barbiturates, often with a combination of alcohol. We continue to receive a relatively low incidence of opium abuse at this time.

Senator Hathaway. What about the Federal effort in this regard? Is it realistic? Are the matching requirements realistic? Do you have a tough time meeting the matching?

Ms. Wolford. Yes; we have a difficult time meeting matching because there are a few local programs under our statewide services program. We are supplying State moneys for match. We are reaching the saturation point where we will not be able to reach, as the State goes down and the Federal goes up.

Sentor Hathaway. Do you find a statewide service contract a good concept for dispensing Federal money?

Ms. Wolford. I think there are some real advantages to it. We have the responsibility for coordinating treatment services on a statewide basis. The statewide services contract gives us more responsibility and more opportunity to do that. We are in the second year of our contract now. We find most of the programs in our State—they are reasonably few at this point—have worked well with us to operate under the statewide services contract.

Senator Hathaway. Do you have any idea how much more money you need to do an adequate job in rural areas?

Ms. Wolford. I can tell you that we could use at least one more major program in the northern part of the State. Most of our drug programing is now concentrated in the southern part of the State where the initial wave of drug problems was felt out of the rest of New England. We are now finding the problem is increasing in the northern areas of the State. We could easily use one residential program there, as well as an outpatient program. Probably upwards of a couple hundred thousand dollars.

Senator Hathaway. Has the effort with regard to drug smuggling been of benefit to you? There was some off the New England coast, the coast of Maine, a few months ago, and the task force has been in place for the last few months. Does this help?

Ms. Wolford. At this point I cannot see any definite impact from that.

Senator Hathaway. You think the incidence is the same?

Ms. Wolford. Yes.

Senator Hathaway. Do you know where the drugs are coming from?

Mr. Wolford. No; I do not, primarily. I think the division of Special Investigation, State Police have information with regard to that.

Senator Hathaway. You say it is multidrug in the rural area?

Ms. Wolford. Yes.

Senator Hathaway. There is not any heroin problem or cocaine?

Ms. Wolford. There is cocaine beginning to show up recently. The heroin problem seems to be still relatively small.

Senator Hathaway. What drug is used most?

Ms. Wolford. I think primarily the drug of abuse according to NIDA at the current time is amphetamines.

Senator **Hathaway**. Do you have any suggestions with respect to either the prevention bill which we will take up tomorrow or the drug bill we are considering now?

Ms. **Wolford**. The bill that you are taking up tomorrow, I find I have relatively little knowledge of. I will take some responsibility for that. I think also there has been a problem in getting the program sponsored by the Office of Education, out to rural areas, and I think the emphasis you have included in that bill to do that is much needed. Primarily larger population centers have applied for and received those grants, and we have received only the peripheral benefits from that, because of our relatively small population base.

Senator **Hathaway**. Is it not required by State law that schools have a drug and alcohol prevention program?

Ms. **Wolford**. In the State of Maine?

Senator **Hathaway**. In the public schools?

Ms. **Wolford**. I do not know what you mean by programs. What I know exists in most cases is relatively little. Some people have 1 day a year kind of presentation or whatever. I think that is hardly a drop in the bucket for what needs to be done in the State.

Senator **Hathaway**. Fine. Thank you.

Mr. Monson.

Mr. **Monson**. Mr. Chairman, and members of the committee, I am Larry Monson, representing today the National Association of State Drug Abuse Program Coordinators. I am here to testify in support of S. 2916, which was introduced on April 15, 1978, to amend the Drug Abuse Office and Treatment Act of 1972.

I am pleased to testify in support of this bill and also want to express our support as an association for S. 2915, the legislation to amend the Alcohol and Drug Abuse Education Act which you will be considering tomorrow. We support both bills and feel that in general that it will do much to strengthen throughout the country in drug abuse prevention and treatment.

It is a pleasure to be joining Dr. William Butynski, president of ADPA and a former State alcohol and drug abuse program director for Vermont, and Ms. Susan Wolford, representing the State of Maine drug abuse program, in appearing before you. I feel that this panel demonstrates the broad commitment of the field to the proposed legislation.

In regard to the bill to amend the Alcohol and Drug Abuse Education Act, I am especially pleased that you are requiring that there be coordination of that activity with the National Institutes on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. I also request that you explicitly spell out that applicants for funds under this act must coordinate their efforts with the recognized state alcohol abuse authorities set up in response to Public Law 91–616 and the recognized single State agencies for drug abuse set up in response to Public Law 92–255.

Too often there have been groups working without sufficient coordination and occasionally even at cross purposes in local communities and in the States. A mandating of cooperation and coordination by the Congress should go a long way to assure that there is no further duplication and lack of coordination of effort. While I recognize the importance and necessity of working with the State education authorities and local education authorities by drug abuse education and prevention programs, it is equally important that the recognized State alcohol abuse and drug abuse authorities be involved. Explicit language from the Congress is necessary to assure this coordination.

I am also happy to support S. 2916 to extend and amend the Drug Abuse Office and Treatment Act of 1972. I am very pleased with the increased emphasis on prevention in its title, as well as providing a separate authorization for prevention and demonstration programs and providing that prevention be included in the technical assistance section. All strengthen the congressional and Federal emphasis on prevention efforts.

There are several other points in the proposed legislation which NASDAPC feels will contribute to strengthening the field of drug abuse, prevention, and treatment. Though we would prefer a 3-year extension of the authorities for NIDA, the 1-year extension for NIDA now and consideration of a 3-year authorization for both NIDA and NIAAA as separate Institutes next year is an agreeable way to proceed. NIDA and NIAAA are now coordinating their efforts in many endeavors as is appropriate. NASDAPC is pleased that the bill will foster further cooperation by including July 31 as the common due date for submission of State plans.

NASDAPC also recognizes that 1 year is an appropriate time to allow the administration to demonstrate its continued efforts to coordinate all Federal efforts in drug abuse without the Office of Drug Abuse Policy. We are certain that the Congress will be monitoring the administration efforts closely and if, after 1 year, there is need for legislative action to assure coordination, such action will be taken next year. The studies of the Office of Drug Abuse Policy represent an important beginning for Federal coordination. The momentum which has begun must not be lost and we expect to join you in monitoring what is done in the coming months to assure that the momentum continues.

NASDAPC is pleased that the Congress is once again confirming the Federal-State partnership which has developed by recommending that formula grant funds in section 409 be authorized for an additional year. NASDAPC notes that the $45 million level proposed is greater than the administration's request for $40 million and thus believes there is room for adequate growth. However, NASDAPC also notes that the $45 million authorization level has now remained static for 5 years. If the partnership is to continue to develop and adequate attention is to be paid to the problems of drug abuse, this level will also need to be increased when authorizations are considered next year for a 3-year period. Such increases will be needed simply to keep pace with the increasing cost due to inflation.

In addition to the provision in this bill for separate authorizations for treatment programs and all other programs funded under section 410 of the Drug Abuse Office and Treatment Act of 1972, the additional funds to be authorized above the administration's appropriation request will also assure that Congress can act to fund adequately prevention and demonstration programs without cutting in the costs of treatment. NASDAPC joins in this desire for adequate funding for the entire spectrum for drug abuse prevention, treatment, and rehabilitation efforts. The $7 million authorization for research on nonaddictive blocking agents and analgesics is a proper reaffirmation of congressional interest in this area. The amounts which this legislation proposes are large enough to allow the Appropriations Subcommittee to make the necessary additions in the administration's proposal for appropriation levels for fiscal year 1979. Changes which the proposed legislation will make in the reporting requirements concerning the marihuana and health report and concerning the annual report now required from the Director of ODAP are also appropriate changes. NASDAPC suggests that the general report to come from the Secretary of HEW also be a biennial rather than an annual one. NASDAPC supports the Congress in its requirement that HEW continue to present to the Congress and to the public adequate information about the continuing problems of drug abuse.

The changes proposed for section 405 require a special report within 120 days of the date of enactment of this legislation and in section 303(2) to provide primary prevention with an emphasis on nonurbanized areas as well as metropolitan areas are likewise appropriate changes. Though the nonurbanized areas of the country as a whole contain fewer people than the central cities and the suburban areas—all too often, problems of drug abuse in such areas are equally severe, if not disproportionately so. The problems of transportation, communication, and provision of effective services when the population is scattered over a comparatively large area often make problems more severe. Even in States which we think of as largely urban. There are frequently nonurbanized areas that have similar problems. Thus, NASDAPC is pleased that the bill focuses attention on the drug abuse problems of such areas. Likewise, the changes proposed for section 409 (e)(7) the act to assure that there will be local coordination with general health planning agencies and educational agencies are positive. They will strengthen the NIDA guidelines, which already require substate planning, and will strengthen the requirements of Public Law 93-641 concerning general health planning. The requirements of the Alcohol and Drug Abuse Education Act for greater coordination, as I mentioned earlier, can also be strengthened by this change.

What I would like to do is divert a moment from my testimony which was submitted and thank you for your continued personal leadership and commend both you and your members for your leadership assuring appropriate responsiveness to both alcohol and drug abuse at the Federal level.

I think prior to my final comment, I want to reemphasize our association's and my personal support, since it was mentioned in your discussion with Dr. DuPont earlier, for Dr. DuPont's leadership as Director of NIDA. I think that he has provided the leadership that has both pioneered and actually solidified a strong Federal-State partnership in dealing with drug abuse. That same type of partnership that has been forged by Dr. DuPont is now having its concurrent effect in pioneering efforts amongst—increasing our efforts between Federal-S[illegible] agencies in the area of alcoholism.

[illegible] conclusion, Mr. Chairman, I want to thank you for your time ar[illegible]e will be happy to answer any questions you may have.

[illegible]ator HATHAWAY. Mr. Butynski, do you want to give us your testimony?

Mr. Butynski. Thank you, Mr. Chairman. We appreciate the opportunity to testify before you. I would like to take the opportunity to introduce our Executive Director, Mr. Hewlett, and in addition to recognize a couple of very significant members of the audience here today, Bill Brooks and Ms. Betty Spence, who are cochairpersons of the National Committee of State Advisory Councils for Alcohol and Drug Abuse.

Mr. Brooks is chairperson of the State Alcohol and Drug Advisory Council in Minnesota, and Ms. Spence is chairperson of the State Drug Advisors Council in Georgia. Through your kind offer, Mr. Chairman, Mr. Brooks and Ms. Spence will be submitting testimony for the record.

I am pleased to bring you testimony in support of your bill S. 2916 to extend much needed and productive programs of the National Institute on Drug Abuse.

I am also pleased to share for the second time, testimony in conjunction with NASDAPC and also am here with a representative from the State of Maine. We support S. 2916. We are particularly pleased you have emphasized the importance of prevention by including the word "prevention" in the title of the law and also including separate authorizations for prevention and treatment programs. This clearly will result in raising a high priority level for prevention efforts, a most timely and positive position.

In terms of prevention, I must respectfully disagree with some of the testimony offered by Dr. Bourne. It is my considered judgment that there is not now nor has there ever been sufficient Federal fiscal support for prevention programs by either NIAAA or by NIDA. While I would agree with Dr. Bourne that we need to intensify our efforts to evaluate prevention programs, we also need more moneys to, in fact, support some prevention programs that can be evaluated. Thus I urge you to maintain within your bill earmarked funds for prevention funds. I think it is absolutely essential. Without such a specific congressional mandate I fear that the meager fiscal support that is now provided for prevention programs will be reduced even further, as in fact occurred within the current fiscal year that provide fewer dollars for prevention than the previous fiscal year.

I think that is a tragedy. I think your bill will go far, in fact, to ameliorate those bad effects, to increase emphasis and positive prevention programing.

In addition we are likewise pleased that your bill would amend section 405 of the Drug Abuse Office and Treatment Act of 1972 by requiring within 4 months of enactment, a report on the nature and extent of drug abuse in rural areas. The ADPA rural alcohol and drug abuse section has shown much concern that the needs in rural areas for both alcohol and drug abuse service delivery differ widely from those of the urban area needs. The leadership in this section is in the process of preparing detailed testimony to be submitted for the record. Your timely response to these special needs by including this provision is especially appreciated by ADPA as a whole and by the rural section of ADPA in particular.

In terms of the rural programs, there is a very real need—and a need, in fact, which up to now has not been addressed—and having served previously as director of the State of Vermont in the alcohol and drug program, also having been born and brought up in New Hampshire, I have a fairly good feel for the needs of rural, nonurban drug programs.

I think it might be well to see what has already been done in terms of reports. I would like to quote very briefly from an NIDA report that has already been published in terms of drug needs in rural areas. This is from an NIDA Services Research Report and Investigation of Selective Rural Drug Abuse programs, page 20:

> Both the data derived from KODAP and anecdotal information contained in a rural survey suggest that the rural drug abuse client is different from his or her urban counterpart. The findings that the rural abuser is comparatively young has a number of implications for both treatment and policy. For example, when client age is coupled with the nature of drugs abused, it suggests that educational, recreational, and psychological resources will be primary in developing a rural client's treatment plan rather than vocational, legal, and social welfare referrals appropriate for the majority of urban centers. The finding that more than one-third of rural clients of 17 years of age or older, compared to less than 7 percent of urban clients suggests that intervention with clients' families may be an important treatment technique for the rural program.

It goes on to say:

> Rural treatment staff bear a major responsibility for educating their client about the drug abuse problem. The boundaries between treatment and prevention which may be observed in urban centers is seen as inappropriate in a rural setting.

This I think ties in well with your emphasis on prevention and a very real need for emphasis on prevention and rural aspects of a drug abuse program.

These have again not been adequately addressed. We strongly support the inclusion within your bill of both of these items.

On another topic we feel it is essential that categorical delivery systems of NIDA and NIAAA be maintained for the foreseeable future until the alcohol and drug abuse field can compete with the other more well established and accepted health and human need problem areas at State and local levels for an equitable share of public funds. The integrity of NIAAA and NIDA as identifiable focal points for that policy direction within ADAMHA is most important.

In terms of the bill to extend alcohol and drug abuse education programs within the U.S. Office of Education, we support this legislation, and essentially agree with testimony offered by the National Association of State Drug Abuse Program Coordinators.

We would agree with the support of Dr. DuPont who we feel has done an excellent job as Director of NIDA.

We are most appreciative of your outstanding leadership and that of your distinguished colleagues on this committee in maintaining sound Federal programing in the alcohol and drug abuse field.

Thank you this, and thank you for the opportunity to testify.

Senator HATHAWAY. Thank you very much.

I appreciate your complimentary remarks.

We are trying to do as much as we can with limited resources that are made available to us.

You have indicated that the problem of drug abuse is at least as equally severe in rural areas as in urban. Did you mean that in numbers or severity or what?

Mr. MONSON. I can respond to it from my perspective. I think it is equally severe in terms of the impact on the community and on the citizens in the area. In fact, it may have more serious impact in rural areas than it does in urban areas, just by the mere knowledge of others in the community that that person is involved and so on. The stigma attached with alcohol is equally there.

I definitely feel rural areas have as much, if not more, the problem with other drug abuse.

Mr. BUTYNSKI. I concur with that, in fact, reemphasize the needs of rural areas. The program in rural areas is more expensive in some respects, distance with staff involved to travel. You still need an administrator, director of the program, be it for 25 treatment slots or 50. I think the reality is that the needs are there. However, in fact, they have not yet been adequately addressed in many areas.

Senator HATHAWAY. Do you want to say anything on that, Susan?

Ms. WOLFORD. I am in agreement with Larry that the impact on the community is particularly important in Maine. A lot of people do not have sophistication about drug abuse or drug problems. The individual suffering the problem not only has whatever are his or her own problems, but also the stigma attached by the community. I would indicate that for an individual who is suffering the problem, whether he or she lives in the city or he or she lives in Calais, Maine, the problem needs to be addressed; particularly in rural areas, they have not been reached.

Senator HATHAWAY. Well, thank you all very much for your testimony and your support for the legislation. We appreciate it.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The prepared statements of Ms. Wolford, Mr. Butynski, and material referred to follow:]

STATEMENT OF SUSAN WOLFORD
DRUG ABUSE PROGRAM SPECIALIST
OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION
STATE OF MAINE
TO
THE SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

Mr. Hathaway and Members of the Subcommittee:

As a representative of the Single State Agency for Drug Abuse Prevention in Maine, I want to address three issues emphasized by specific provisions of the bill to amend the Drug Abuse Office and Treatment Act of 1972. The first important issue is that of drug abuse prevention and treatment in rural areas. The magnitude and the visibility of drug abuse problems in the large population centers of this country have combined to obscure the growing problems of drug abuse in its rural areas. Our experience in Maine and the information shared with us by people working in similar environments demonstrate that there exists a major rural drug problem: indiscriminate use of a variety of legally and illegally obtained drugs, including the drug alcohol. This widespread polydrug abuse is characteristic of both sexes at all age levels. In Maine, the number of clients who are abusing one or more drugs at admission is steadily increasing in both alcohol and drug programs.

Historically, by far the largest share of federal resources appropriated for drug abuse services has been allocated to urban areas. Rural areas, with few local resources and a minimal share of federal resources, have had to struggle to establish, and fight to maintain, the most basic levels of service. The methods used for distributing even those minimal resources have proved that the federal government does not adequately recognize the costs required to operate small rural programs serving people in large geographic areas. Furthermore, the administration of federal resources has been tailored to the nature of the drug abuse problems in urban areas and to typical urban systems of service delivery. Therefore, in order to use any resources which are available to rural areas, we must comply with administrative standards that do not reflect the dimensions of the problems we encounter. For example, the Federal Funding Criteria for drug treatment services established by the National Institue on Drug Abuse (NIDA) creates administrative difficulties for rural programs.

It insists on the delivery of specific medical services and it establishes hours of program operation and the amount of counseling time to be provided. Given the scarcity of medical services, the relatively low incidence of opiate abuse and its associated physical costs, and the small size of treatment staffs in rural areas, such criteria are unrealistic if universally applied.

In addition to the problems which arise in rural areas from the lack of adequate resources and the application of inappropriate administrative standards, the separation between alcohol services and drug services at the federal level fails to acknowledge the reality of the polydrug abuse problem that we must address. We find ourselves forced to reflect the categorical funding distinctions of the Washington bureaucracy rather than able to respond to the actual problems and needs of our people. Categorical funding and its requirements are designed to meet needs in urban areas where large groups of people can be identified who share specific problems. On the other hand, it is essential that rural services be integrated to insure efficient, cost-effective delivery to those people who require them.

We in Maine feel strongly that the concerns related to rural areas which are outlined above should be addressed in the report to Congressional committees that this bill requires from the Department of Health, Education and Welfare. We specifically suggest that the assistance of people working in rural areas be obtained in the preparation of that report and we offer our cooperation.

The second issue that I want to discuss is that of prevention services. In Maine, the need to provide drug prevention services has long been apparent to farsighted individuals, both within and without the substance abuse field. However, in the past two years, support for such activities has gained momentum, becoming widespread and vocal. During that time, our office has developed its concept of drug prevention which focuses on the use of all drugs and which targets potential drug abusers at all age levels. We have translated that concept into a prevention model calling for intensive, community-wide efforts. We believe that efforts involving key groups, individuals and institutions in the community can have the greatest impact on the problems of drug abuse. It is our further conviction that rural areas where people live in closely knit communities and rely on community resources for basic goods and services offer excellent possibilities for testing that prevention model. Therefore, in 1977, our office introduced a bill to the 108th Maine Legislature which proposed funding locally-based prevention efforts in selected pilot communities of the State. Although the bill ultimately failed to pass, it did gain a majority of legislative votes during its initial consideration.

In rural areas, prevention activities perform two important functions which need to be specifically mentioned. First, prevention can furnish a necessary link to treatment services. Since it is likely that drug treatment will continue to be primarily available in larger towns and cities, education and information must be provided to the most rural areas in order to insure referrals to appropriate treatment services. Secondly, prevention activities can provide accurate information about drug use and its associated problems to people living in rural communities. Their current sources of information are often national media sources which describe urban drug problems and may employ scare tactics to discourage drug use. Realistic education is needed to counter the effects of that information.

We therefore support the general prevention emphasis in this bill and the particular provision requiring a separate appropriation for programs directed at people who are not yet experiencing serious harm from drug use. Furthermore, we think it is vital that federal funds for prevention activities be distributed through the Single State Agencies to permit coordination of what should be comprehensive, statewide efforts.

The third and final issue is coordination of drug abuse prevention functions at the federal level. During recent months, we have observed early signs of cooperation between NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), primarily in the areas of prevention and training. Since we operate as a combined agency for alcohol and drug abuse prevention, we welcomed those signs. However, we have yet to reap concrete benefits from that federal cooperation. We would like the opportunity to observe the progress of the cooperative efforts for another year and would therefore support the extension of NIDA's authorization for only one year. If NIDA's and NIAAA's authorizations are both considered next year, we will be prepared to provide specific suggestions on areas and ways in which the activities of the two Institutes can complement each other for the benefit of people who need drug abuse services.

STATEMENT OF

WILLIAM BUTYNSKI, PRESIDENT

ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

BEFORE

SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

ON

EXTENSION OF NATIONAL INSTITUTE ON DRUG ABUSE

APRIL 19, 1978

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am pleased to bring testimony in support of your bill, S-2916, to extend the much needed and productive programs of the National Institute on Drug Abuse. I am also pleased, for the second time in as many weeks, to share the witness stand with friends representing our sister organization - the National Association of State Drug Abuse Program Coordinators (NASDAPC). The Alcohol and Drug Problems Association of North America (ADPA), which I am privileged to represent, is exclusively involved in the full range of professional interest concerning issues related to both alcohol and other drugs. Members include public programs at all levels of government; private programs, voluntary, profit and nonprofit; and individuals with professional interest in the field. NASDAPC is a close ally with whom ADPA shares many common interests and concerns. Most of the state alcohol and drug abuse authorities are members of both organizations. It is fitting, therefore, that we are together this morning just as we were on April 10 before the House Committee concerned with the same issue.

We support S-2916. We are particularly pleased that you have emphasized the importance of prevention by including the word "prevention" in the title of the law and by including separate authorizations for the prevention and treatment programs. This clearly will result in raising the priority level for prevention efforts - a most timely and positive position.

We are likewise pleased that your bill would amend section 405 of the Drug Abuse Office and Treatment Act of 1972 by requiring within 4 months of enactment a report on the extent and nature of drug abuse in rural areas. The ADPA Rural Alcohol and Drug Abuse Section (RADA), a special interest section and an important component of ADPA, has shown much concern that the needs in rural areas for both alcohol and drug abuse service delivery differ widely from those of the urban area needs. The leadership of this section is in the process of preparing detailed information in support of this provision for inclusion in the record for these hearings. Your timely response to these special needs by including this provision in S-2916 is especially appreciated by ADPA as a whole and by the Rural section of ADPA in particular.

ADPA supports the Congressional intent expressed by your amendment of Section 503 to provide a separate authorization of $7 million during the coming year for research on "blocking agents" for heroin, morphine and other opiate derivitives.

We also strongly support your Section 6 which amends Section 502 of the Marihuana and Health Reporting Act (PL 91-296) to require a biennial rather than annual report. We would recommend that the same amendment be applied to Section 405(b) of the Drug Abuse Office and Treatment Act of 1972 (PL 92-255). Such an amendment would have beneficial effects, i.e., the President, the Congress and the field would have one major report every two years to peruse rather than one, one year and two every two years. The state of the art for drug related problems as a whole does not seem to warrant a yearly review in toto any more than does the state of the art in marihuana. The two year interval would allow for a more comprehensive review than is possible for a one year interval. This is because of the delays in the bureaucracy for approval - approximately 60 days. No sooner would the Secretary, through NIDA, complete one annual report than he would have to begin on another - using the same or only slightly different data.

Whereas, we would much prefer to see Congress enact a full three year extension of NIDA this year and of NIAAA in 1979, we understand your reasons for proceeding with a one year extension. We understand that this is being done at a time when the phase out of the Office of Drug Abuse Policy and other actions resulting from the President's Reorganization Plan Number One create some uncertainties on the part of Congress concerning coordination and policy direction of all federal drug abuse programming. We also understand that a one year renewal of NIDA is not being done now with the idea that NIDA and NIAAA should be merged next year. This, in our view, would be most premature.

It is essential that the categorical delivery systems of NIDA and NIAAA be maintained for the foreseeable future until the alcohol and drug abuse fields can compete with the other, more well established and accepted health and human need problem areas at the state and local levels for an equitable share of public funds.

The maintenance of integrity of NIDA and NIAAA as identifiable focal points for national policy direction within ADAMHA is most important. Policy and procedural differences in the Institutes' handling of grants and contracts, data collection, etc., however, need to be resolved so that the increasing number of combined alcohol and drug abuse agencies which deal with both institutes will not continue to be burdened with two such disparate systems. There is now close communication between the institutes and much has been done in recent months to rectify some of these differences. They are to be commended for this and encouraged to continue in this direction.

Monetarily, we feel the levels you propose are realistic, although we would prefer to see more.

Since we are in agreement with Mr. Monson's testimony which addresses other specific provisions of S-2916, I shall not belabor the points he will make with duplicate testimony.

Finally, Mr. Chairman, our organization is most appreciative of your outstanding leadership and that of your distinguished colleagues on the Committee in maintaining sound federal programming in the alcohol and drug abuse fields. Thank you for this and thank you for the opportunity to be heard today.

RADA Rural Alcohol & Drug Agencies

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April 24, 1978

The Honorable William D. Hathaway
Chairman, Subcommittee on
  Alcoholism and Drug Abuse
United States Senate
246 Russell Senate Office Building
Washington, D.C. 20510

URGENT URGENT URGENT URGENT URGENT URGENT

Dear Senator Hathaway:

I have not been able to submit our testimony to the Subcommittee's hearings on the reauthorization of the Drug Abuse Office and Treatment Act of 1972 until now.

It was not until today's mail brought the drafts of your Amendments to the Act that I was able to comment upon them. As you know, your staff's difficulty in reaching me by phone and the slowness of communication by mail in itself exemplifies certain rural problems in service delivery that rural staff face daily.

But I do hope that it will be possible to include my attached testimony, which is coming to you special delivery. I must also add that each week I receive letters from rural people looking for rural alcohol and drug materials. The need is strong and pervasive, and I hope to locate funding to meet such informational needs. If you or your staff has any suggestions on potential sources of assistance, I would appreciate learning of such information.

Thanks so much for the Amendments and providing a place for rural America in your work.

Sincerely, Robert T Maslyn

Robert T. Maslyn
Chairperson

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TESTIMONY OF

ROBERT T. MASLYN, CHAIRPERSON

RURAL ALCOHOL AND DRUG AGENCIES OF NORTH AMERICA

"RURAL POLICY CONCERNS REGARDING THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972"

Presented to the
Subcommittee on Alcoholism and Drug Abuse
of the U.S. Senate Human Resources Committee
HEARINGS

April 19, 1978 Washington, D.C.

adpa ALCOHOL AND DRUG PROBLEMS ASSOCIATION
OF NORTH AMERICA
1101 FIFTEENTH ST., N.W. WASHINGTON, D.C. 20005

My name is Robert T. Maslyn, chairperson for Rural Alcohol and Drug Agencies of North America, the first and only national organization specifically concerned with rural alcohol and drug problems.

At the outset, I wish to express my warm appreciation to Senator William Hathaway for extending an invitation for RADA to personally testify on this reauthorization hearing on the Drug Abuse Office and Treatment Act of 1972.

Unfortunately, and quite frankly, I did not have the money to come to Washington and testify and thus requested that my time to appear before this Subcommittee be deferred to the Alcohol and Drug Problems Association. The testimony of ADPA and RADA should be considered as separate presentations.

Permit me to make a point about that before we leave it. The situation of countless numbers of rural-based alcohol and drug program directors speaks of similar inability to afford the costs of coming to Washington. In their absence is parade after parade of well-financed urban-based and urban-thinking directors. Not only are rural substate directors not usually present at hearings tables but it extends to other decision-making tables: formulation and comment upon regulations, drafting legislation and special programs, and grant review tables.

If the work of this Subcommittee is to include rural areas, then it must go to rural areas. The recent hearings held by Senator Hathaway in Maine initiated this process and RADA commends this action. But it is only a beginning and critics might retort that it was too much the tip of an iceberg to matter.

As the Chairman knows, RADA has formally requested Subcommittee hearings on Rural Alcohol and Drug Problems in a rural location in each of the ten federal regions. The Subcommittee response at this time is that a "legislative backlog" precludes such hearings; our response is that a legislative backlog will always be the case and that initial work could proceed on scheduling such hearings now, for 1979. Indeed, it would be appropriate to consider hearings also on the day preceeding or the day succeeding the "co-located" meetings of ADPA and the National Drug Abuse Conference. The co-location conference should be the largest assemblage of alcohol and drug personnel ever, and, if the usual NDAC practice of stipends for travel is followed, perhaps more rural people would be present. It could be a rare opportunity.

In passing, let us all note that the Senate Special Committee on Aging has provided the precedent for rural-located hearings when it held a series of at least seven hearings on the Nation's Rural Elderly from August 1976 to March 1977.

Drug Abuse Office, Prevention and Treatment Amendments of 1978

Bill S.2916, the Drug Abuse Office, Prevention and Treatment Amendments of 1978, must be applauded for its two major emphases, prevention and rural (or nonurban) equity.

The nature of the rural condition necessitates a significant amount of time and effort focused upon prevention activities. We know that people in rural areas use what they can get and, thus, that their drug use is multiple in nature. We know that communities of small sizes and spatially dispersed result in community attitudes playing a significant role in what drugs and alcohol will be used, misused and abused, with whom, when and what will happen with those who experience serious alcohol and drug problems. In a sense, the community might then be seen as the client.

But prevention activities must also include community recruitment, support and education. No drug and alcohol program could long exist in any rural area without a variety of support actions by the community. For the staff of such programs, creating and maintaining community support involves a great deal of time, time that is often not funded, even though it is essential, due to the heavy emphasis upon treatment monies.

Prevention in rural areas must also consider the close attachments of rural families. Drug and alcohol problems of one family member may often be "matched" by mental health or mental retardation problems of other family members, not to mention unemployment, child abuse, suicide attempts, environmental health problems, nutritional problems and other complications. Once again, a prevention emphasis is the practice, even though funding and specialized training in prevention have been generally absent.

Secondly, the rural or nonurban report on drug abuse that the Amendments require of the Secretary should be approved by the Congress, if the Congress seeks to at long last learn of the special differences of rural areas and the policy implications of such differences.

But I wish to caution the Subcommittee on a glaring problem with any such report at the outset. First and foremost, the experience of rural programs is that, whether they are categorically funded for alcohol or for drug, the staff must and does service both drug and alcohol clients and, in fact, the clients usually are using both alcohol and drugs anyway. The potential problem of a report on rural drug situations is that it may attempt to exclude alcohol or, at least, underplay it.

Highlighting a portion of funding for nonurban purposes, as the Amendments do, should again merit the approval of persons seriously interested in drug problems, no matter in what place they may occur.

Urban programs, with the assist that urban media provides, with full-time grantspeople and specialized managers, with access to power centers, have drawn heavily on grant and formula monies while rural programs, lacking crucial resources for their own advocacy, have received a disproportionately smaller share of program and research monies. This becomes an even more serious state of affairs when one considers that rural conditions, at the very start, require higher operating costs for rural programs than do urban conditions for urban programs. Equity is the key concept that needs to be applied to all programs.

The general absence of responsiveness of the National Institute on Drug Abuse to rural differences must be examined. While NIDA has conducted two studies on nonurban drug abuse programs, the policy and programmatic direction of NIDA has yet to reflect any change of a meaningful character, thus far. For example, where NIDA has invited grant applications from rural areas, it has complained that the programs have not submitted many applications and of the applications submitted, few contain adequate research components, essential to grant approval. It seems clear that there may be issues in that experience that warrant better outreach to rural programs and technical assistance to programs that lack research expertise.

Alcohol and Drug Abuse Education Amendments of 1978

RADA has previously testified and supported the Alcohol and Drug Abuse Education Act as being an important program in addressing rural program needs. The new Amendments of 1978 sensitize the Act to rural areas in important ways. It seems it is necessary to earmark a portion of funding for nonurban areas in order to insure a more equitable distribution of funding patterns and it is most welcome. The team concept emphasized by the Office of Education in implementing the Act is especially suitable to the rural community conditions. The Amendments are also significant for the new Office of Alcohol and Drug Abuse Education proposed and that such an Office work closely with the Alcohol, Drug Abuse and Mental Health Administration. This cross-categorical approach makes sense; a cross-funding mechanism would also be appropriate so that the rural school and the rural alcohol and drug program can acquire joint funding through a common office and a common application process.

Further Observations

The Drug Abuse Office and Treatment Act of 1972 happens to share the same year of passage with the Rural Development Act of 1972. Both were born of separate efforts by different constituencies, yet the commonality of both bears mentioning. Both attempted to launch a new effort nationally to address a serious problem, one of drug abuse, the other of rural decline.

The Congress ironically is now considering the aforementioned Drug Abuse Office and Treatment Act amendments as well as amendments to the Rural Development Act, the Rural Development Policy Act of 1978. It would seem to be appropriate that this Subcommittee examine the Rural Policy amendments and consider specific inclusions, in the language, of drug and alcohol problems.

It is also suggested that the Subcommittee consider legislation that would bring together the training, prevention and clearinghouse arms of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. Rural areas, once again, are oriented in most cases to serving both alcohol and drug clients, and the differing emphasis, types of services and amount of assistance from the two institutes may more tend to frustrate the rural director than assist. The training, prevention and clearinghouses must also be reviewed for the amount of rural-oriented materials and approaches they have. The current state is that much of the materials and approach presumes an urban context, thus becomes inappropriate for the rural staff member.

It is also suggested that the Subcommittee and, indeed, the Human Resources Committee, begin to examine rural human services integration programs. Drug and/or alcohol dollars fund a rural program that may also provide mental health, youth, aging, and transportation services, in addition to drug and/or alcohol services.

It is recommended that the following amendment to the Drug Abuse Office and Treatment Act of 1972 be considered: Support in Communications and Transportation Activities: The Secretary shall direct the establishment of a Support in Communications and Transportation Activities (SCAT) grants assistance program at a cost of $3,000,000 [illegible] to support the expenses of non-urban drug program staff activities in non-mobile and mobile telephone communications and transportation activities performed in delivering services to non-urban residents.

Clearly, the high costs of transportation and communications in rural areas drains a major portion of operating expenses, affecting consequent levels of services, salaries and evaluation costs. It is further suggested that communications be initiated with the Department of Transportation and HEW and other appropriate bodies to consider transportation monies for human services programs in a special program initiative.

Summary

1. Hearings need to be held in a rural location in each of the ten federal regions on Rural Alcohol and Drug Problems. Hearings should be considered, additionally, to phase in with the co-located meetings of ADPA and NDAC.

2. The Drug Abuse Office, Prevention and Treatment Acts of 1978 successfully address the drug policy concerns of rural areas as does the Alcohol and Drug Abuse Education Amendments of 1978.

3. The Subcommittee might consider its own amendments to the Rural Development Policy Act of 1978, to include drug and alcohol problems in the Rural Development Act of 1972.

4. Legislation should be considered which would bring together the training, prevention and clearinghouse arms of

NIDA and NIAAA; further examination of rural human services integration, inclusive of drug and alcohol services, is warranted.

5. The Drug Abuse Office and Treatment Act of 1972 should be amended to include:

> Support in communications and transportation activities: The Secretary shall direct the establishment of a Support in Communications and Transportation Activities (SCAT) grants assistance program at a cost of $3,000,000 to support the expenses of non-urban drug program staff activities in non-mobile and mobile telephone communications and transportation activities performed in delivering services to non-urban residents.

I wish to thank the Subcommittee and its staff in its consideration of rural areas.

STATEMENT OF PRESIDENT
MONSIGNOR WILLIAM O'BRIEN
THERAPEUTIC COMMUNITIES OF AMERICA
TO THE SENATE SUBCOMMITTEE ON
ALCOHOLISM AND DRUG ABUSE

Therapeutic Communities of America, (TCA) is the national association which represents drug free residential treatment modalities. Our organization supports S.2916 which extends and amends the Drug Abuse Treatment Act of 1972.

We support the continuation of a strong federal role in the financing of treatment programs. The emphasis on prevention in the bill is a significant policy statment, and the treatment programs which are members of our association welcome an opportunity to extend our role into a more active educational stance in our local communities, in addition to providing a temporary haven for individuals who need a structured environment to resolve drug abuse problems and related personal difficulties.

TCA supports the requirement of Section 3 for an annual report which, among other things, evaluates the effectiveness of drug abuse prevention programs initiated under the aegis of the Department of Health, Education and Welfare. In the past, there has often been a sense that funds used in the prevention area have not had a sufficiently direct impact on the potential drug abuse population to produce any meaningful results. This need not be the case if there is sufficient experimentation with the peer counseling system and similar methods which avoid the appearance of one age or socio-economic group superimposing its value system upon another group.

We would particularly like to emphasize the need to retain a mechanism highly placed in the Executive Department to focus on demand and supply reduction in the drug abuse field, whether it is retained in the form of a section of the Domestic Policy Staff or through the "Strategy Council" which is currently operating. Since national changes in demand and supply occur extremely rapidly and often without much advance warning, a clearly defined, yet flexible Federal mechanism is necessary to initiate and coordinate policy changes in the area. It is hoped that the provision for a one year extension of the Act will offer a forum in 1979 for renewed vigorous debate on this issue and reevaluation of the need for a specific White House office to develop policy. It should also provide the opportunity to evaluate the current Domestic Policy Staff arrangement in terms of visibility and effectiveness. The one year renewed authorization for NIDA and consideration of a three year authorization for NIDA in 1979 is viewed in a similar perspective by TCA.

In conclusion, TCA wishes to thank Senator Hathaway for his continued committment to the maintenance of high standards in the drug abuse treatment and prevention field.

STATEMENT OF

MS. BETTY P. SPENCE AND WILLIAM F. BROOKS, JR.
CO-CHAIRPERSONS OF

THE NATIONAL COMMITTEE OF STATE ADVISORY COUNCILS
FOR ALCOHOL AND DRUG ABUSE

BEFORE

SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE
ON S. 2916

A BILL TO AMEND THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972

APRIL 19, 1978

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE:

I am Betty Spence, the Chairperson of the Georgia Drug Abuse Advisory Council, and with me is Mr. William Brooks, Jr., Chairperson of the Citizens Advisory Council on Alcohol and Drug Abuse of Minnesota. We are the Co-Chairpersons of the National Committee of State Advisory Councils for Alcohol and Drug Abuse. We are here to testify in support of S. 2916, the Bill to amend the Drug Abuse Office and Treatment Act of 1972, and to express support for S-2915, the Bill to amend the Alcohol and Drug Abuse Education Act, which you will be considering tomorrow.

The National Committee of State Advisory Councils for Alcohol and Drug Abuse is a relatively new group from the standpoint of organizational life but as individual state advisory councils, we have been functioning nearly as long as the Drug Abuse Act. We are favorably impressed and support S-2916. We want to speak to some specific portions of the Bill in more detail.

As citizen advisors to the professionals in the state alcohol and drug abuse agencies we have long felt that much more should be done in the area of prevention. We are pleased to see that this Bill not only increases the emphasis on prevention, but also that it does it without sacrificing the much needed assistance in the treatment and rehabilitation efforts. The inclusion of the word "prevention" in the title of the Bill shows your commitment.

Since we both come from states which are generally considered to be among those described as being more rural than metropolitan, the additional emphasis you are directing to rural needs in the field is heartening. The 1960s and early 1970s focused, rightly so, upon the heroin epidemic in the large inner city areas. As with other social problems, drug abuse has become a rural concern in the past few years. We find that alcohol-drug and polydrug abuse are very prevalent in rural sections of the country rather than the drug specific phenomenon of the cities in the last decade. It is essential that adequate prevention, treatment, and rehabilitation services be directed to this special target population. We strongly support this thrust in the proposed legislation.

We are pleased to be associated with the Alcohol and Drug Problems Association of North America and would like to take a moment to echo and add our endorsement to that portion of Dr. Butynski's earlier testimony concerning the need for continued and increased cooperation among the ADAMHA institutes. One specific area in which ADAMHA can bolster coordination efforts of NIDA and NIAAA might be guidelines which would make it easier for states with combined alcohol and drug programs to submit a single comprehensive state plan for approval. Another area where coordination needs to be improved is data collection. A great deal of productive time is taken from local treatment and rehabilitation programs to complete duplicative paper work on clients. Improvement through a single or better coordinated data gathering system would release much of this time to be used in client-counselor, etc., activities, which we feel is more cost beneficial.

The continuation of Section 409 discretionary funds is very important to citizens advisory councils and state program directors. This mechanism, while maintaining the necessary federal oversight, enables state policy makers to design programs flexible enough to meet the varying needs across the country. This helps to strengthen the state-federal partnership begun in the original P.L. 92-255.

I will briefly touch on Sections 410, 502 and 503. The separate authorization of $7 million for research on blocking agents is to be applauded. The amendment of the Marijuana and Health Reporting Act should provide policy makers and program directors with a more comprehensive information base for future directions than the present reporting method. Separate authorizations for Section 410 funded activities assure that treatment costs support will not suffer while the new emphasis on prevention and demonstration projects are being launched.

In conclusion, we want to clearly state again that we support S-2916. While we have not specifically addressed S-2915, because it is not the subject of today's hearing, we would like to go on record as supporting that Bill also.

Thank you for the opportunity to be heard.

Betty P. Spence
Betty P. Spence

William F. Brooks, Jr.
William F. Brooks, Jr.

Co-Chairpersons
National Committee of State Advisory
Councils for Alcohol and Drug Abuse

Senator HATHAWAY. The hearing is now adjourned.

[Whereupon, at 11:53 a.m., the hearing was adjourned.]

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